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**"The nature and use of knowledge by district nurses in decision making
relating to first assessment visits"**

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Abstract

District nurses are the largest group of community nurses in the United Kingdom and an important aspect of their role is the responsibility to assess the health needs of patients at home. To date there has been limited exploration of the knowledge or decision-making underpinning needs assessment in district nursing practice. The aim of this study was to explore knowledge in use by district nurses at the first assessment visit and the relationship of this knowledge to the decisions they make.

The inherent difficulties in exploring the knowledge and decision making of experienced district nurses demanded a systematic and interpretative research approach where the impact of the context could be examined. An ethnographic approach was adopted for the study as the focus on perspectives and activities in the natural setting and the substantial reliance on observation of real examples provided a starting point for this study.

Eleven district nurses were accompanied on a first assessment visit. Each district nurse was interviewed twice, immediately following the observed visit and then approximately one-year later when preliminary data analysis had been undertaken.

This approach to the study revealed a breadth and depth of community nursing knowledge that seemed to incorporate an amalgam of theoretical (knowing that) knowledge with practice based (knowing how) knowledge. The study findings depict the range and scope of the knowledge in use by district nurses and challenge the utility of theoretical models which remove knowledge from the context in which it is used and applied. The most striking findings relate to the influence of the context in which the DN/patient interaction takes place and the reflexive character of the assessment process.

In particular, the study illuminates the ways in which DNs utilise a range of cues throughout the assessment process. The information search in assessment is often 'paced' to cope with the uncertainty that exists in many of the complex, multifaceted situations encountered by the DN. Understanding assessment as a paced process was linked to making the best judgement at the time of the first visit.

A model of district nurse assessment, which seeks to illuminate the process of assessment, is presented. In particular, this model seeks to highlight the reflexive nature of the assessment process. A typology of district nursing knowledge, which conceptualises six dimensions of practice based knowing in district nursing practice, is also presented. Strategies for decision making are revealed through the application of Carroll and Johnson's (1990) theoretical framework.

Recommendations are given for future research and the educational and professional context in which DN practice exists. It is suggested that further research should take cognisance of the ongoing nature of assessment in the community setting. A study conducted over a longer period of time, exploring further the impact of the context on the assessment process, seems particularly important.

Given the paced approach to needs assessment and the ongoing nature of assessment identified by the study participants, it is suggested that the qualified DN should be contributing to needs assessment on a continuing basis. This recommendation is counter to recent trends in the skill/grade mix in the DN team which emphasise the need to reduce rather than increase the numbers of qualified DNs. Additionally, given the emphasis on family care by the DNs in this study, it is recommended that DNs should record and examine this important area of their work, so that this aspect of the DN role is identified and acknowledged.

Finally, the importance of experiential learning depicted by the participants in this study suggests that work-based and problem-based learning approaches may be the most appropriate way in which to teach DN students about assessment. The findings are therefore important for the education of current and future DNs.

This study contributes to the knowledge of assessment practice by increasing understanding of the ways DNs work in relation to the first assessment visit. The model of assessment illuminates the process of assessment and the typology aims to provide a conceptualisation of knowledge in use. Furthermore, the ways in which DNs make decisions is revealed. Therefore, the study findings can inform the education of present and future DNs to the potential benefit of patients and their carers.

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“....knowledge underlying nursing grows like a spiral. There can be no end point as the universe will never be totally mastered. It is this continuous never ending potential to create and use further knowledge, the opportunity for ongoing learning, that not only enables nursing to develop its all important body of knowledge but also makes life exciting and worthwhile for us all”.

Lisbeth Hockey, 1996 (Pg. 5)

From: Hockey, L (1996) The nature and purpose of research **In** Cormack, D (Ed) The Research Process in Nursing (3rd ED.) Oxford, Blackwell Science

CHAPTER ONE: AN INTRODUCTION TO THE STUDY

1.0 Introduction

This chapter provides an introduction to the study by describing its origins, the role of the district nurse (DN) and the policy, professional and educational context in which the study was conducted. The initial research questions and an outline of the approaches adopted to answer them follow the rationale for the study.

1.1 The origins of the study

The researcher's own experience as a DN for 13 years and as a teacher of DN students for almost 6 years stimulated the desire to explore the nature of first visits in district nursing practice. Impressions from experience in practice and education seemed to suggest that first visits were complex, unpredictable and a delicately balanced interaction between the DN and patient and/or carer.

Experience as a DN suggested that giving care at home required knowledge and decision-making skills well beyond those identified in the DN textbooks of the day. As a teacher of DN students, the researcher also maintained close links with district nursing practice. This experience highlighted how difficult it was in a classroom setting to prepare students for their role, a situation compounded by a relative lack of empirical work in relation to DN practice. Additionally, although knowledge development in nursing has increased, evaluation of the impact of context on care is limited. As DNs are the main providers of nursing care to patients and families at home it was judged to be important to explore the work of DNs in relation to first assessment visits.

The aim of this study was to explore the nature of the knowledge required by DNs to carry out first assessments and the relationship of this knowledge to the decisions they make. To date, many studies of DNs have focused on tasks and procedures, caseload management and skill mix issues rather than on knowledge which underpins decisions and activities in work with patients and their carers (McIntosh and Richardson 1976; Dunnell and Dobbs 1982; Badger et al. 1989; Hurst and Costin 1990). Exceptions include the work of Bryans (1998) and Worth (1999).

Bryans (1998) explored aspects of knowledge in use in relation to everyday community nursing assessment. This study uncovered a wide range and variety of knowledge in use and revealed the complex and implicit nature of the knowledge base required for assessment practice. Bryans (1998) suggested that some elements of knowledge were community-nursing specific. In addition to biomedical knowledge and knowledge derived from the social sciences, the DNs also had knowledge of the local resources and community in which they worked. Worth (1999) analysed the assessment process in district nursing and social work and identified a wide variation in the approach of DNs to the assessment of older people. Her study identified that DN assessment remains service driven rather than being needs-led. Given that needs assessment is a key aspect of the DN role, it seems essential to add further to the body of knowledge surrounding assessment.

1.2 The role of the district nurse in relation to first assessment visits

District nurses are the largest group of community nurses in the United Kingdom and provide skilled nursing care for patients and support for carers living in the community (Audit Commission 1999). The DN is a Registered Nurse who has undergone additional post-registration education in order to achieve a recognised qualification as a district nurse (UKCC 1994a; UKCC 1994b). The role, which normally encompasses a wide range of responsibilities and involves working with other members of the primary health care team, has been defined as follows;

"The district nurse is the leader of the district nursing team within the primary health care services. Working with her may be RGNs, ENs and nursing auxiliaries. It is the district nurse who is professionally accountable for assessing and reassessing the needs of the patient and family, and for monitoring the quality of care. It is her responsibility to ensure that help, including financial and social help is made available as appropriate...." (Department of Health and Social Security 1977 Pg. 8).

Although dating back more than 20 years, this definition reflects current components of the DN role. Overall responsibility for assessing and planning how patients' and families' needs are met remains an essential element of the DN role (Royal College of Nursing 1993a). It is normal policy that the qualified DN will admit and discharge patients from the caseload and the first assessment of patients' needs is crucial to the planning of future care (Department of Health and Social Security 1976).

Assessment in nursing practice is the first stage of the nursing process. The nursing process, which consists of four stages, assessment, planning, implementation and evaluation, is considered to be a problem-solving approach (McCarthy 1981; Taylor 1997). Assessment as a process is generally associated with the gathering of information from a range of sources and sensory cues including observation, sight, hearing and smell. Needs assessment in health care is recognised as a complex process and has been described as "...a diagnostic process leading to suitable medical and nursing interventions" (Vernon et al. 2000 Pg. 282). Links between needs assessment and service provision are normally made, as is the recognition that needs assessment is the first stage in a process that seeks to improve a person's situation or functioning by providing suitable interventions (Worth 1999).

Normally the DN and patient will not have met prior to the first assessment visit and it is generally accepted that the DN is a 'guest' in the home of the patient (McIntosh 1981). The first visit therefore represents the beginning of the DN/patient relationship, which may span a considerable period of time:

"The importance of the initial encounter between the nurse and the patient cannot be overstressed since it may form the basis of a relationship lasting for years" (Baly 1981 Pg. 104).

Referrals to the DN service for a first assessment visit may arise from a number of sources including the GP, hospital staff, and other professional staff including social workers or from the patient and/or carer. Worth et al (1995) identified that most referrals to the DN service came from the GP. The second most frequent source of referral was hospital staff with relatively few referrals coming from other professionals or the patient or carer. Referrals may be made in writing by the GP or hospital based staff. In the study by Worth et al (1995) the telephone was the most frequently used mode of communication for referrals following hospital discharge. Referrals are usually framed as a task such as 'assess for bath' or 'wound check'.

DNs normally respond quickly to the request for a first assessment visit. Worth et al (1995) identified that DNs responded to 77% of GP referrals within 24 hours. Luker (1996) claimed that the DN service normally responded to all referrals within 48 hours in contrast to the Social Service Departments where patients may not be seen for several weeks or months after referral.

Assessment of need is one of the core skills required by district nurses. It is important to consider factors from the policy, professional and educational context that are influencing the role of the DN in needs assessment.

1.3 Changes in assessment: the policy context

Changes in the National Health Service (NHS) since the 1980's have occupied a central place in political debate. Patterns of health service delivery have changed as a result of implementation of the National Health Service and Community Care Act (Public General Acts 1990). Reforms in the NHS have given priority to care given at home and within communities. The reforms also differentiate between health and social care and local authorities have the responsibility to design, organise and purchase social care. Practitioners were challenged to deliver needs-led rather than service-led assessment and the separation between responsibility for assessment of needs and provision of services has impacted on the assessment role of the DN. The implications of these changes are discussed further in Chapter 2, Section 2.2.2.

Evidence suggests that the changing emphasis from institutional care to care in the community may be influencing the work of the DN including her role in needs assessment. In a survey of the impact of community care on the work of district nurses, 79% of the DN respondents highlighted an increase in workload with a corresponding rise in stress also identified by 79% of the study participants (Ballard 1994). Only 15% of DNs reported increased job satisfaction since implementation of the Community Care Act. The sample for this survey was 950 members of the RCN's District Nursing Forum who were selected at random. Members of the DN Forum were selected in order to ensure as many of the sample as possible held a DN qualification. Although the postal questionnaire achieved a low response rate of 41%, there were 375 usable responses and eighty-five per cent of the respondents had a specific DN qualification (Ballard 1994).

Barrett and Hudson (1997) reviewed the work of the DN services in an inner London Health Authority in 1992, 1993 and 1994. In contrast to the above survey, they found that the number of patients seen by the DN service remained stable, although by 1994 there was a significant increase in those aged over 85 years. If more elderly people are being assessed by the DN service this has implications for the workload of DNs and the services required to meet needs identified through the assessment process.

Barrett and Hudson's (1997) review of DN work suggested that since the introduction of the NHS and Community Care Act there had been a change in the nature of DN work within the area studied. In addition to the increasing number of elderly patients the most significant change was the greater emphasis on technical care in 1994. The authors describe technical care as giving medications, blood sugar and blood pressure monitoring, catheterisation and ear syringing. New knowledge and skills may therefore be required to ensure that DNs are able to meet the needs of their patients.

In 1997 the change of Government in the United Kingdom and the establishment in 1999 of a Scottish Parliament have resulted in further policy changes which reinforce the role of primary health care. The White Paper, 'Designed to Care' (The Scottish Office Department of Health 1997) sets out the new system which replaces the internal market in health care. The White Paper required the setting up of Primary Care Trusts (PCT) and Local Health Care Co-operatives (LHCC). In England, the new frameworks designed to develop inter-agency partnerships in primary care are emphasised in 'The New NHS: Modern, Dependable' (Department of Health 1997).

Primary Care Trusts (established in April 1999 in Scotland) are responsible for managing local primary healthcare services. The PCT is accountable to the Health Board and has responsibility for the allocation and use of resources and for the quality of care provided. The LHCC's are voluntary networks of GPs and replace the GP fundholding system introduced in 1989 (Department of Health 1989). These co-operatives can hold a budget for primary and secondary services and have responsibility for purchasing and providing quality services within a specified budget. Identifying and meeting health needs of the local population and commitment to health improvement and disease prevention programmes are fundamental to their objectives. The full implications of these new working arrangements for DNs are not yet known.

Although the notion of a 'primary care-led NHS' is frequently cited, there is a lack of clarity about what this means in practice. The unique and privileged position of DNs has been emphasised and DNs have been urged to delineate the boundaries of their work in order to maintain control rather than allow other professionals, including GPs, to influence development of the district nursing service (Luker 1996). Due to the complex nature of the nursing contribution to primary care, it will be necessary for community nurses to contribute to the development of individual practice and to primary care nursing

development generally (Latimer and Ashburner 1997). DNs therefore need strategies to enhance development of their professional identity whilst contributing to policy development in primary care.

Opportunities for DNs to develop their role have also been identified in the Audit Commission Report 'First Assessment' (Audit Commission 1999). This review of district nursing services in England and Wales stated that although the DN service was responsible for delivery of most of the professional nursing care in patients' homes, that the priorities and objectives of the service are ill defined. DNs are challenged to modernise their services if they are to meet the health care needs of communities, patients and families.

Thomas (1999) reported a development, which she argued, was exactly the type of initiative the Audit Commission (1999) was seeking. This initiative involved the setting up of a rapid response district nursing team in Bolton. The primary aim of this team was to provide the necessary care to maintain patients in their own homes and prevent admission to hospital. Patients who required interventions included those needing blood transfusions and treatment for deep venous thrombosis. Patients who required interventions such as IV therapy, re-hydration, treatment for acute infections and palliative care were also cared for at home (Thomas 1999). It is unclear how this service differs from that proposed by past initiatives such as Hospital at Home and how this will impact on DNs generally and specialist outreach nurses from the hospital setting. The inclusion of palliative care is surprising, as this is a recognised part of the DN role (Barclay et al 1999).

It is clear that DNs are faced with a number of challenges as a result of health and social policy changes. Health care provision in the UK is characterised by the particular emphasis being placed on improved efficiency and increased accountability. Changes in health care provision have occurred in parallel with an ageing population, a pre-dominance of chronic disorders, renewed emphasis on prevention of ill health and finite resources (Littlewood 1995; Goodman 1996).

The shifting emphasis from secondary health care to primary health care means that patients, often with needs for specialist care, are being discharged home from hospital earlier and more patients with acute and degenerative illness are being cared for at home. Earlier discharge from hospital has implications for the specialist knowledge and technical skills the DN may require. Hospitals carry out more non-invasive surgical procedures and

cases of day surgery resulting in a shorter length of patient stay in hospital (Stanwick 1994; Lock 1995; The Scottish Office Department of Health 1996). It is not yet clear from nursing literature if these non-invasive procedures are impacting on the role of the DN as many patients require no follow up care in the community or hospitals may provide their own specialist outreach nursing care. The changing epidemiological and demographic trends indicate the need for community nurses who are flexible and able to respond to change (Sines 1995).

1.4 Changes in assessment: the professional context

District nursing has a long history dating back to the middle of the 19th century and has evolved from the need to nurse people, particularly the poor, in their own homes. Although nurses had always worked in people's homes, Florence Nightingale introduced the first wave of reforms in an attempt to organise home care (Baly et al. 1987). District nursing was formalised by William Rathbone, a wealthy shipowner in Liverpool, who paid for a nurse to care for his wife. Mr Rathbone consulted with Florence Nightingale about the possibility of training nurses to look after the sick in their own homes and the first district nurse training was undertaken at Liverpool Infirmary in 1863.

In 1887 a donation of £70,000 from Queen Victoria's Jubilee Fund was given for an extension of the work of district nursing. Following the setting up of the Queen's Jubilee Institute, who laid down principles and ideas for education of district nurses, DNs became known as "Queen's nurses", a name still recognised by many elderly patients today (Baly 1980; Lock 1995).

After the First World War, district nursing continued to develop with most patients having to pay for nursing care. The DN was often responsible for collecting the fees. Major social reform and the introduction of the Welfare State resulted in the establishment of the National Health Service (NHS) in 1946 and implementation in 1948. District nursing was then provided free at the point of use by all local Health Authorities (Lock 1995) and the ideology of welfare remains the foundation of district nursing practice (Ross 1990).

The role of the DN as leader of the DN team has been clearly identified for some time (Department of Health and Social Security 1977). Working with the DN may be Registered Nurses, District Enrolled Nurses and Nursing Auxiliaries. Although the team leader role

was identified 20 years ago it has been suggested that ten years ago qualified DNs were still providing most of the direct care (Lock 1995). Increased responsibility, as team leader is a direct consequence of the expansion of skill mix within the DN team. Following the recommendations of the Report produced by the NHS Management Executive (1992) - *Nursing skill mix in the district nursing service* - most health authorities and health boards have employed more staff at different grades in order to maximise resources (National Health Service Management Executive 1992). However, despite this, the DNs who participated in this study still provided most of the direct caregiving

The important distinction between grade mix and skill mix has been highlighted. Grade mix refers to the numbers of staff at each grade which has cost implications for employers - the lower the grade of staff, the less the manpower costs. Skill mix however, relates to the skills and experience of the staff within each grade (Gibbs et al 1991).

Although skill/grade mix was established within DN teams, the recommendations outlined in 1992 by the NHS Management Executive recommended a significant shift in the grade mix within the DN team. This report, known as 'The value for money report', suggested that 26% of the workforce should be G or H grade (qualified DNs) and around 65% at D or E grade. The remainder of the workforce would comprise untrained staff (approximately 9%) (National Health Service Management Executive 1992). It is important to acknowledge that even within one grade, individuals by virtue of interest, personal values and expertise bring different knowledge and skills to the job.

The radical proposals contained within this report were based on the conclusions that the DN service was top heavy with qualified DNs doing work that could have been carried out by less qualified workers of lower grades. The report argued that first assessment and re-assessment visits represented less than 3.5% and 10% respectively, of the qualified DNs workload. As responsibility for assessment lies with the qualified DN employed at G or H grade it was argued that the balance of qualified staff needed to be reviewed as most of the work carried out by these grades of staff was the same as lower, less qualified staff. However, the crude methods adopted to inform the recommendations, a task based activity analysis, were widely disputed (Goodman 1996).

The recommendations contained within the Value for Money Report also prompted a robust response from the Royal College of Nursing who challenged the proposals and

argued that many aspects of the DNs role required the experience of the G or H Grade nurse. These included assessment and reassessment of health needs and a range of activities relating to health promotion and education (Royal College of Nursing 1993b).

Statistics confirm that there has been a change in the balance of qualified DNs and registered nurses working in the community. Over the period 1994 – 1995 there was a reduction in the numbers of qualified DNs (-2.6%) and an increase (+8.5%) in the numbers of registered nurses without a DN qualification who work in the DN team (Information and Statistics Division The National Health Service in Scotland 1996). Whilst these figures do not reflect the recommendations of the 'Value for Money Report' which suggested that around 65% of the workforce should be D or E grade, there has been a change in the composition of the DN team.

Implementation of skill mix within the DN team has implications for the role of the qualified DN. The DN may currently be undertaking more of a team leader role with responsibility for caseload management. Whilst the role has always involved caseload management, as the team leader the DN will delegate work to other members of the DN team after the first assessment visit. The DN will then visit periodically to reassess patient and/or carers needs. This means that the DN will deliver less direct care and will require to make decisions about delegating the work to other members of the team and decisions about when patients should be re-assessed. It has been suggested that many DNs may perceive these changes in role to be challenging (Lawton 1994). It could be argued that increased responsibility for leadership and management issues and less direct caregiving will impact on the decisions made by the DN who may no longer carry out every visit.

DNs have been, to date, the main group providing care outside the hospital setting. In the United Kingdom during the 1970's small numbers of practice nurses (1500) were directly employed by GPs to work in the surgery. By 1994, the numbers had risen to 17500 and the rapid increase in numbers of practice nurses employed was a direct result of implementation of the 1990 GP Contract (DOH 1989). GPs were able to seek direct reimbursement for practice staff (Stillwell 1995). In Scotland there was a 39% increase in the numbers of practice nurses employed from 1990/91 to 1994/95 (Information and Statistics Division The National Health Service in Scotland 1996).

Developments in practice nursing are important in relation to the role of the DN. Practice nurses have expanded their role to incorporate elements which may previously have been the responsibility of the DN. Atkin et al (1993) reported in their survey of more than 12000 practice nurses in England and Wales that over half the practice nurses visited patients at home and carried out activities including assessment of patients aged 75+, immunisations and clinical investigations.

Ross (1990) has urged community nurses, regardless of who employed them, to take stock and work together to meet the needs of the community they served. This could be difficult, as practice nurses who are employed by GPs, may not perceive themselves as free to engage in such collaboration. The Audit Commission Report (1999) recommends that DNs extend the provision of clinic based services for patients who are able to attend on a planned basis. The possible impact of such a move on the role of both DNs and practice nurses is hard to determine. It will be important to establish dialogue between DNs and practice nurses in order to compare approaches and examine the contribution of each group to needs assessment.

1.5 Changes in assessment: the educational context

Parallel to change in the practice context, education for community nurses has also undergone change. Programmes for pre-registration nursing qualifications provide a baseline for practice in the community (UKCC 1986). The Post Registration Education and Practice Report (PREP) sets out the UKCC standards and requirements for maintaining registration and for programmes of education which lead to specialist practitioner qualifications (UKCC 1994a; UKCC 1994b).

Specialist practitioner programmes for district nursing are set at degree level and are an amalgam of theory and practice-based learning. The PREP requirements identified that specialist practitioners would be expected to:

“...exercise higher levels of judgement and discretion in clinical care in order to function as specialist practitioners...They should be able to demonstrate higher levels of clinical decision making and will be able to monitor and improve standards of care...” (UKCC 1994a Pg. 3).

Understanding the knowledge used to make decisions when assessing health needs is therefore important. The implications for DNs are explored further in Chapter 2, Section 2.3.

1.6 Rationale for the study

Assessment is seen as a key component of the DN role and as a cornerstone of community care (Public General Acts 1990; Lock 1995). The DN requires skills in assessment and an extensive knowledge base on which to formulate decisions relating to patient care. Such decisions may include how often the patient requires to be visited, what resources are available to meet identified needs and the suitability of other grades of staff to visit and give care after the initial assessment. However, very little research has been undertaken in this area.

A major proportion of the healthcare budget for the community is currently spent on staff and the debate continues about the most appropriate balance of qualified to unqualified staff (Audit Commission 1999). It is unlikely that the particular remit of the DN in relation to first assessment visits will be unchallenged in such a climate. Additionally, as Bryans (1998) identifies;

“Current information systems about the work of district nurses emphasise simple, quantifiable aspects of practice – such as physical tasks, or the number of patients visited – neglecting the quality of care...” (Bryans 1998 Pg. 3).

Given the current emphasis on evidence based practice there is an urgent need to ensure that DNs/DN students and educators can draw from an empirically derived and sound evidence base, which includes knowledge and evidence derived from systematic research approaches, both quantitative and qualitative (National Health Service Management Executive 1994; Closs and Cheater 1999).

The role of the DN in needs assessment emphasised by the community care policy identified in Section 1.3 made this study timely. Additionally, the fact that DNs were likely to require new knowledge and skills to equip them for their role in needs assessment added to the justification for carrying out the study.

An initial review of the literature confirmed the current interest in patterns of knowledge in nursing practice. Additionally, practitioners' or personal knowledge is acknowledged to be a largely untapped resource by writers including Benner (1984), Meerabeau (1992) and MacLeod (1996). McIntosh (1996) reiterates Meerabeau's argument in relation to district nursing practice and suggests that there is an urgent need to distinguish between the technical rational type of knowledge (know that) based on empirics, and the know how (professional artistry) type of knowledge described by Schön (1991).

Although decision-making is central to nursing practice, the literature about clinical decision-making in nursing is relatively new and much of it originates from North America. It has been suggested that an understanding of how expert and experienced DNs make decisions is essential, particularly in a period of rapid change (Orme and Maggs 1993).

1.7 The initial research questions and the approach taken

Having identified the relative lack of understanding about the DN role in needs assessment and the possible implications of changes in policy, practice and education, it was considered to be important to explore this area further. A number of research questions were initially framed:

What do we know about the purpose of the first assessment visit?

What do we know about the process of DN assessment?

What do we know about how the values and knowledge of the DN impact on the assessment process?

What do we know about the impact of policy on DN needs assessment?

What do we know about the impact of education on DN needs assessment?

What do we know about the way in which DNs make decisions at the first visit?

What are the factors that influence decision making at the first visit?

It was considered that a focus on the knowledge and decision-making processes underpinning the first assessment visit would help to uncover the contribution of the DN to needs assessment. Three broad research questions were then framed:

1. What is the nature of the knowledge base used by DNs when undertaking first assessment visits?
2. What is the basis of decision-making by DNs during first assessment visits?
3. What is the relationship between the knowledge base of the DN and her decision-making practice?

The study explored these issues using a blend of qualitative research methods. In order to gain a comprehensive understanding of what DNs do and why they decide to do certain things at the assessment visit, it was unlikely that a single research method such as interviews would suffice. Whilst interviews alone may have provided useful information relating to the DNs' perceptions of their assessment practice, they were unlikely to reveal how assessment visits were actually conducted. Participant observation of DNs at work combined with in-depth interviews was identified as an appropriate method to allow the description, interpretation and explanation of many important issues relating to first assessment visits in district nursing practice. The research methods used in this study are discussed in Chapter 3.

1.8 Organisation of thesis

In Chapter 2 the literature review is reported in three main sections:

- Exploration of the concept of need and district nurse assessment
- The nature of nursing knowledge
- Clinical judgement and decision-making.

The literature review confirms that needs assessment is a complex process and that to date, there has been limited exploration of the knowledge and judgement processes underpinning needs assessment in district nursing practice.

Chapter 3 presents the research approach adopted for the study. The description of the sampling methods, the approaches that were adopted to the interviews with the DNs and the observation of their assessment practice reveal the practice focus of the study. This discussion is set within the context of the ethical issues that arose and the approaches adopted to the analysis of the data.

In Chapter 4, the main themes and categories derived from the data are presented and discussed and a model of district nurse assessment and its component parts is presented. A typology of knowledge for district nurse assessment practice, developed from the study data, is presented in Chapter 5. A case study in Chapter 6 illustrates an example of district nurse assessment practice and seeks to illuminate the relationship that exists between the knowledge used by the DN in the assessment process and her decision-making practice.

In the final Chapter 7, findings from the study are discussed and recommendations for future research, education and practice are made. The extent to which the aims and objectives of the study have been met are considered and the strengths and limitations of the research approaches adopted are evaluated.

(Whilst it is recognised that there are male DNs, the eleven participants in this study were female. This reflects the general situation where the majority of DNs are female. For consistency, 'she' is used when referring to DNs throughout).

CHAPTER TWO: THE LITERATURE REVIEW

2.0 Introduction to the literature review

The aim of this study, to explore the knowledge and decision-making of district nurses in relation to first assessment visits, encompassed several complex issues. Literature relevant to this study was drawn from a range of sources. The search was designed to explore a range of theoretical and empirical literature in relation to the concept of need and community nursing assessment, the nature of nursing knowledge and clinical judgement and decision-making. A comprehensive review of each of these topic areas was outwith the scope of this thesis. The literature review was therefore designed to encompass selected literature that pertained to the aims of the study.

There is currently limited literature in each of the three subject areas identified above that specifically relates to community nursing assessment. Our knowledge of community nursing assessment practice is restricted to a few studies. There is no shortage of literature relating to knowledge and decision-making generally but a considerable proportion of the literature relating to knowledge lacks an empirical base and is theoretical or anecdotal in nature.

Literature contained in this review was drawn from a range of disciplines including medicine and psychology. Theoretical and empirical literature relating to knowledge and decision-making was analysed alongside literature relating to community nursing assessment.

2.1 Literature search strategies

Throughout the study on-line computer searches of several databases including CINAHL (Cumulative Index to Nursing and Allied Health Literature) were undertaken. The results of these searches were limited. The key words 'district nursing' with 'assessment' produced few references relevant to this study (CINAHL 1982-1996: 1997-1999). A search using the key words 'nursing' with 'decision-making' and 'community nursing' with 'decision-making' revealed a limited number of studies. Additional literature relating to decision-making was uncovered by searching Medline (1985-1990: 1991 – 1995: 1996 – 2000) and Psychlit.

In addition to online searches, manual search methods proved to be useful. The seminal work of Carper (1978) provided a starting point. Manual methods which included tracking significant references from articles such as that by Carper (1978) and Benner (1984) were used. This approach to literature retrieval, although time consuming, was productive. Bryans (1998) reported similar difficulties in identifying research-based literature for nursing knowledge and DN assessment. Similarly, Worth (1999) identified that most of the literature relating to DN assessment was didactic rather than research based. Bryans (1998) and Worth (1999) both reported having to undertake manual searches to uncover relevant literature.

Throughout the study, further on-line searches were undertaken in related areas such as family carers, family nursing, communication and a range of research issues. The bibliographic management package 'Endnote' was used to ensure accurate storage and retrieval of reference materials. This software proved to be an extremely useful resource as the processes of refining and re-ordering sections of this thesis were undertaken.

2.2 Introduction: The concept of need and community nursing assessment

"Within the community nursing service, the district nurse is leader of the district nursing team and is professionally accountable and has continuing responsibility for: assessing and reassessing the care needs of the patient and the family; planning, implementing and evaluating a programme of care; monitoring standards of care; managing the caseload" (District Nursing Association 1995 Pg. 17).

The ability to assess needs and plan and effect appropriate care for patients and carers at home is a key skill required of the qualified DN. The requirement for all patients to receive a needs assessment from a qualified DN was stated over 20 years ago (Department of Health and Social Security 1976). Assessment of patients' and carers' needs remains the cornerstone of NHS and Community Care policy (The Scottish Office Department of Health 1997; The Royal Commission on Long Term Care 1999) and assessment is therefore an important element of the DN role.

The NHS and Community Care Act drew a distinction between health and social needs (Public General Acts 1990). In the community, DNs were identified as the key professionals in relation to assessment of health needs and social workers as the key professionals in assessment of social needs. It has been argued that this divide was not

helpful to health and social care workers as the boundaries between health and social needs may be arbitrary (Øvretveit 1992). Since implementation of this Act, the Social Work (Service in England) Departments have been responsible for maintaining people in the community including those who are elderly and people with chronic disabilities, learning difficulties or mental illness (Mansfield 1992; Cowley et al. 2000). For many patients at home, the divide between social and health needs may seem artificial, particularly in relation to some areas of care including meeting personal hygiene needs (Worth et al. 1995). Inability to attend to personal hygiene may be both a social and a health related issue or problem. The divide between health and social care is further complicated as NHS provision is free but entitlement to social care is means tested.

Implementation of the NHS and Community Care Act signalled a change from service led to needs led assessment (Public General Acts 1990). Worth suggested that identifying need for district nursing could occur at three levels – that of the community, the GP practice or at the level of the individual patient and family. She suggested that the contribution of the DN tends to be reactive, focusing on the assessment of individual needs within the context of available resources. Generally, the GP or hospital staff identify the need for DN intervention thereby restricting the contribution of DNs to the development of needs led services (Worth 1996). The requirement for DNs to be involved in needs assessment at the level of the patient and family and to contribute to needs assessment and service planning at both practice and community level has been reinforced (Luker 1996; Audit Commission 1999; Moore 2000).

Official guidance in relation to needs assessment was provided for practitioners by the Social Work Services Group (SWSG) in 1991 following implementation of the NHS and Community Care Act (1990). This group suggested that care management should begin with needs rather than services. They argued that it was crucial that “...all care agencies and practitioners share a common understanding of the term ‘need’”. Accordingly, they defined need as:

“...the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social dependence or quality of life, as defined by the particular care agency or authority” (Social Services Work Group 1991 Pg. 12).

It is important to note that this definition highlights the role of the agency or authority in determining need rather than the individual. These guidelines also emphasise the value-laden components of individual need and therefore offer limited practical advice for practitioners who are involved in needs assessment on a daily basis.

2.2.1 Individual need and needs assessment

“The role of nursing is first and foremost to respond to human needs; in today’s world these needs are continually and rapidly changing; and community health nursing, like other parts of the nursing profession, must change with them” (Royal College of Nursing 1992 Pg. 4).

Despite widespread agreement that nurses aim to meet the needs of patients, the concept of need is used variously and has been described as a complex and confusing concept which lacks clear definition (Smith 1980; Worth et al. 1995; Endacott 1997). This is further complicated by the fact that ‘needs’ and ‘wants’ are often referred to synonymously and exactly which needs are the concern of health care professionals, including DNs, is often unclear and influenced by available resources.

Need is widely accepted to be a socially constructed concept (Ong 1991). Within the context of community nursing, in addition to an evaluative element, need also has social and relative elements. Need is a changing state (relative) that is influenced by the accepted standards and values in the community and society (social) in which an individual exists. Need is also influenced by the value judgements (evaluative) of those involved (Orr 1992). Defining needs in the community setting is therefore a complex process, which is likely to be influenced by a number of contextual issues in addition to the values of the patient and nurse involved.

In nursing, need is normally linked to assessment and this section of the review has its focus on perspectives on need in order to aid understanding of the assessment process in district nursing practice. This sets the context for the discussion of assessment and community nursing practice that follows.

Perspectives on need

At the level of individual need, Maslow (1954), a pioneer of human psychology, proposed a hierarchy of needs in which basic physiological needs take precedence over psychosocial needs. Maslow suggested that individuals will only be motivated to meet higher needs such as self esteem needs, cognitive needs, aesthetic needs and achieve self actualisation when basic safety and physiological needs are met (Maslow 1954). Within this hierarchical model, needs are seen as driving the individual. However, this model assumes that the individual will be driven towards meeting their needs and does not account for individual choice.

More than 25 years ago, Bradshaw (1972) provided a Taxonomy of Need which was originally devised to clarify social needs but continues to have relevance to the health care context. Bradshaw (1972) sought to legitimise wants by referring to them as *felt needs*. In addition to *felt need*, Bradshaw identified three further categories of social need: *normative need*, as defined by the expert or professional, *expressed need*, felt need turned to action and *comparative need* which arises where similar populations receive different service levels. Whilst this taxonomy may be useful to distinguish between different types of needs at individual and community level, practitioners require pragmatic help in identifying and prioritising needs in practice.

Farrell (1991) argued that once we move away from identifying individual basic needs such as the need for air, food shelter and warmth then the concept of need becomes a difficult one. French (1983) sought to distinguish between needs and wants by suggesting that whilst wants can be deferred, needs must be satisfied. It has also been suggested that needs are 'means to ends' and that needs are 'for' something, whereas problems can simply exist (Seedhouse 1994; Worth 1999). However, reaching agreement on whose perception of need is most important remains problematic. The criteria used to identify needs are often not explicit and may be professionally determined rather than patient-led.

Liss (1993) developed a model for the assessment of health care need and proposes that needs only exist if there is a gap between the actual state of the person and the goal to be achieved. Therefore, an individual needs X when X is necessary to reach a goal. This goal focused approach helps to distinguish need from want where the satisfaction of need is instrumental for achievement of the goal. The purpose of needs assessment then is to

identify whether meeting the so-called needs through health care could fill this gap. Liss identified three stages when assessing the individual's need for health care:

- **Establish the actual state of the individual;** this stage involves establishing the person's actual ability to meet his goals. In health care, clinical examination and interview are normally used to determine the actual state of health. Worth (1999) suggests that if the term 'observation' is used instead of clinical examination, this stage of the model becomes more relevant to DN practice.
- **Settle the goal of health care need;** Liss suggests this distinct stage of the assessment process involves making the value-laden component of the process explicit. It involves reaching agreement with the subject of the interventions, the patient and/or family, on the desired goals.
- **Determine the object of need if there is a difference between the actual state and the goal of health care need;** this stage involves the information gathering and decision-making part of the assessment process. The physical and psychological state of the patient and the alternatives for settling the goal of need are considered. Liss emphasises that whilst the first two stages can be reversed, this third stage must follow them. (Liss 1993)

In relation to DN (and social work) practice:

"Need is judged to exist when there is a difference between the actual state of the person and the optimal level of health; intervention is necessary in order to attain optimal health. Therefore, X needs social work or district nursing services (the object of need) in order to attain or maintain, their life goals (the goal of need)" (Worth 1999 Pg. 73).

Given the various situations that the DN may encounter when assessing patients at home, establishing an 'actual state' as suggested by Liss, may be difficult. Additionally, whilst the model provided by Liss seeks to make the value-laden component of need visible by 'settling the goal of health care need', some of the difficulties inherent in this process are likely to remain. The varying perceptions between the individuals who are potential recipients of DN services - the patient and/or family - and those of the DN, who also has to work within available resources, may be difficult to reconcile. In health care, an important

question is whose values determine the choices made for action – the patient or the provider's?

The influence of resources on the assessment of need

In day to day practice, health care professionals require to work within available resources. Hinds described needs as “The perception of a discrepancy between the resources available and those required” (Hinds 1985 Pg.576). This definition suggests that needs are the result of some form of ‘gap’ between the actual and desired state and acknowledges that the availability of resources is fundamental to the meeting of identified needs. Therefore the health care professional has to identify the overall needs of the patient and prioritise decisions about those needs that can be met from available resources.

In the community setting DNs have access to a range of resources and services and knowing what is available may influence how they identify and meet the needs of patients. For example, if the DN knows that a local hospice has places available for respite or day care, she may be more likely to suggest using these resources to meet some of the needs of a patient (and carer) who requires palliative care. Similarly, if she knows the waiting list is so long that the patient and family are unlikely to benefit from hospice support, then she is less likely to offer these services at the assessment visit. Therefore, the care offered to patients has to be confined within the services available (Vernon et al. 2000).

In an ethnographic study of district nursing work involving 37 DNs, Griffiths (1996) discovered that ‘rationing’ of services by DNs was indeed part of the assessment process. The DNs in her study identified needs which could not be met within available resources. However, the DNs concealed the needs which could not be met from the patients, by not articulating these, and from service providers, by not recording unmet need. Strategies for rationing services included restricting the help offered at the first visit, and, emphasising that where significant help was given to patients, this would not be on a long-term basis. Griffiths also suggests that DNs ration care based on the relative values placed on different ‘types’ of patients. Examples were observed where DNs prioritised the needs of terminally ill or younger patients over older patients (Griffiths 1996).

The realities of implementing needs-led assessment within service constraints may result in difficult decisions for practitioners. Worth (1999) used Liss's work as a theoretical framework for the analysis of the data concerning the assessment practice of DNs and social workers as the model "...allows the separation of needs assessment from assessment for services, but also explains how the two are linked" (Pg. 84). Practitioners also need to establish ways of achieving such a goal in day to day practice.

Which needs are the concern of the DN?

Goodman (1996) identified what she termed the 'invisibility' of district nursing, suggesting that relatively little is known about district nursing work in comparison to other areas of nursing practice. As the DN normally works alone, how she carries out aspects of her role is relatively unmonitored, therefore, evaluating the accuracy of the assessment process in identifying patient's needs is difficult (Audit Commission 1999). The role of the DN has tended to be described in terms of tasks rather than interactions with identifiable emotional and social support components (Coombs 1984; Worth et al. 1995).

The available range of literature about needs assessment in DN practice presents a complex picture with some authors identifying that some DNs meet a narrow range of needs (normally physical needs), whilst others suggest that many DNs carry out a 'holistic' assessment. For example, in a study of the long-term care needs of stroke patients at home it was identified that DNs had difficulty defining their needs and consequently patients had unmet needs (Kratz 1978). There is some evidence to suggest that even where patients with disabilities were being visited on a regular basis by the DN service that some unmet needs remained; Williams and Bowie found that 40% of disabled adults in their survey had unmet needs for aids, services and benefits. They found that those who were in contact with the Social Work Department were less likely to have unmet needs (Williams and Bowie 1993). Worth (1999) identified differences between DN and social work assessment. The DNs in her study concentrated on health, safety, functional ability, environment and support networks and gave less attention to social needs and material circumstances. The social workers included a wide range of information in their assessments but in less detail with health and environmental issues receiving least attention.

Bryans (1998) counters the view that DNs assess a narrow range of needs by suggesting that many of the DNs in her study had a "...broad approach to assessment which encompasses psychosocial aspects of patient need" (Pg. 298). Inevitably, given the range and complexity of the situations which DN's may encounter and the acknowledged impact of personal values on needs identification, variations in practice are likely to occur. Hockey (1979) identified some time ago that the 'work preferences' displayed by the DNs in her study were linked to their values and "...the work they do or omit to do" (Pg. 273).

Determining individual needs is therefore a complex process and there is no one agreed DN framework for assessment. Distinguishing between needs and wants is problematic and patients and health care professionals may hold conflicting values which may influence their individual perceptions of need. Service/resource constraints also impact on needs assessment and knowledge of the resources available in the community is likely to impact on the process of needs assessment as DNs may be reluctant to uncover needs they cannot address.

To date, available evidence presents a complex picture about the DN role in needs assessment and exactly which needs are the concern of the DN is unclear. Some evidence would suggest that the DN service meets a fairly narrow range of needs. However, research by Bryans (1998) indicates this may be changing and that many DNs are aware of the necessity to identify physical **and** psychosocial needs.

2.2.2 Assessment in district nursing practice

Findings of a study of the district nursing service in England and Wales (Audit Commission 1999) identified assessment as an area of practice which is a major determinant on the outcomes of patient care and therefore linked to the overall quality of care provided. However, the findings suggest that standards of assessment practice vary and the quality of assessment, as carried out by DNs, is not monitored. Several areas were noted as requiring attention; the need for standardised documentation, guidelines for assessment and continuing education for DNs.

Nurses are encouraged to adopt a problem solving approach to needs identification and assessment (Miller and Bancock 1996). Assessment is a familiar term used in every day nursing practice and represents the first stage of the nursing process. The nursing process is

considered to be a problem solving approach and its introduction has been regarded as an attempt to enhance analytical decision-making in nursing practice (McCarthy 1981; Taylor 1997). The nursing process is an example of a descriptive model of decision-making but links between this process and decision-making are rarely cited in nursing literature. The nursing process is normally used in conjunction with models of nursing and both are considered to represent systematic approaches to nursing practice (McKenna 1997).

Luker (1988) identified that nurses may use either formal or informal models to guide their practice. Maslow's (1954) hierarchy has been used to develop theoretical models for nursing practice and Henderson suggested 14 basic needs: breathing, eating and drinking, elimination, movement and posture, sleep, suitable dress, control of body temperature, clean body, avoiding dangers, communication, free worship, meaningful activity, recreation and learning and discovery (Henderson 1966). Twelve categories of basic need or activities of living have been incorporated within a framework similar to that of Henderson (Roper et al. 1990), and many nurses in the United Kingdom have attempted to use this model of nursing. However, there has been limited evaluation of the impact on patient care of using such models in practice (McKenna 1997).

The nursing process and nursing models have been criticised for being complex to use, irrelevant to practice and also for encouraging nurses to assume that using such an approach to assessing and planning nursing care will 'always' result in the correct identification of patient needs (McKenna 1997).

Defining assessment

Assessment is generally associated with the collection and review of information to allow the problems of the patient to be identified (Roper et al. 1996). This view suggests that assessment is an objective process that can result in the identification of problems and needs. In contrast Crow et al (1995) suggest that the assessment process has subjective elements with the purpose being to:

"...form an evaluation or judgement about a condition, not a diagnosis of a problem" (Pg. 207).

It has been said that through the assessment process, DNs aim to evaluate:

“...the physical, intellectual, emotional, spiritual and social needs of their patients and carers as a means of reaching a nursing diagnosis” (Mackenzie 1989 Pg. 15).

While this definition reflects the holistic approach to needs assessment advocated for community nurses, the idea of nursing diagnosis is not widely accepted in the UK context due to the association with the medical model of care (Crow et al. 1995; Ross and Mackenzie 1996).

Influences on district nursing assessment

In the community setting a number of factors are likely to influence assessment. For example, Ross and MacKenzie (1996) identified that the way in which the DN carries out a needs assessment is influenced by her philosophy of practice and her knowledge, experience and personal values. This claim reinforces the values based component of needs outlined by Orr (1992) and discussed above. In order to meet the needs of the patient, the DN has to collect a wide range of information from different aspects of the patient's life. It seems likely that the manner in which the DN approaches the assessment will influence how much information the patient is willing to share with her. Additionally, assessment in district nursing practice is normally a continuous process in a relationship that may span a considerable period of time. The home circumstances of the patient and the level of family support available may vary and therefore influence the assessment process, in different ways, at different times.

Ross and Mackenzie (1996) emphasise that assessment should be patient centred and not confined to a particular professional framework or checklist of questions. However, such tools may be viewed as important aids to the assessment process by providing a framework to guide the process (Buckley and Runciman 1985). Although district nurse assessment may encompass identifying physical, social and emotional needs, exactly which needs are the concern of the DN is not clear. For example, if a patient has advanced disease, the DN is likely to help with a number of physical and psychosocial care needs. However, the DN may not consider that all the needs of the patient are her concern; if the patient and his or her partner have financial problems as a result of the illness, it is difficult to determine the extent to which this is the concern of the DN. It has been identified that DNs are less likely to explore financial status with their patients than social workers (Worth 1999). In

this current study, some DNs did discuss how patients might be encouraged to use the Attendance Allowance to pay for services including bathing. Therefore, DNs may be selective about assessing financial status and more likely to do so where services, such as the bathing service, are limited.

Multi-professional perspective and understanding of assessment

In the community setting, the range of health care professionals who may be involved further complicates needs assessment. Buckley and Runciman (1985) explored the health assessment of older people at home as carried out by 11 professional groups including DNs, Health Visitors and General Practitioners. This study identified that there was a wide variation in the approach of different professionals to the needs assessment of older people. The majority of the health professionals who participated in the study did not have a comprehensive framework of assessment within which they could operate. There was considerable overlap in assessment frameworks but each professional group had its own particular orientation to assessment. In all the professional groups there were gaps in relation to identifying physical and psychosocial needs. The researchers suggested that if the perceptions of the patient and professional about the scope and purpose of the assessment were similar then there was an increased chance that the outcome of the assessment would benefit the patient. Although the DNs generally demonstrated a positive attitude towards the assessment of older people, a lack of clarity about the purpose and process of assessment was evident (Buckley and Runciman 1985).

One of the main outcomes of the study by Runciman and Buckley (1985) was a prompt list for health care professionals involved in the assessment of elderly people (Appendix 1). The 46 categories contained within this list provide guidance about the scope and content of DN assessment and reflect physical elements of assessment including mobility and the ability to meet hygiene needs. Psychosocial elements of need such as the mental state of the person, the suitability of the home environment, support available from family and friends and the support required from other services were included. Recognition of the influence of the context on the potential needs of the patient was identified some time ago:

“Whilst the functions of the district nursing sister are comparable to those of the ward sister, the domestic, social and environmental factors of her patients often result in complex situations of a kind dissimilar from those met in hospital” (Scottish Home and Health Department 1978 Pg.15).

Use of such a prompt list may help to guide DNs to determine; what they need to know; what to look for and observe and what to ask about during assessment. When using assessment tools practitioners need to utilise these to guide but not constrain their assessment practice as any one tool is unlikely to cover all the complex situations which the DN may encounter.

There also exists potential for the patient and/or carer and the DN to differ in their expectations as to who should meet identified needs. In an ethnographic study of 10 DNs, Ong (1991) aimed to understand the needs of patients and carers receiving DN care, and he identified three interpretations of the role of the DN from the patient's perspective. Some patients wished to maintain their life within normal parameters and saw the role of the DN as supportive. Other patients had clearly defined views and expectations as to which tasks the DN should assist with; physical care and advice were seen as the main contributions of the DN. The last group saw the role of the DN as one dealing with all aspects of their needs including clinical, social and emotional needs.

Ong (1991) questions the notion of holistic approaches to care, as advocated by nursing models. In relation to those patients who saw the role of the DN as assisting with physical care, this approach would be inappropriate. Ong argues that holistic assessment is only appropriate to those patients and carers who consider their needs "...straddle the health and social-psychological boundaries" (Ong 1991 Pg. 646). In other words, a DN may have to negotiate with the patient and decide whether to take a comprehensive/holistic approach to assessment or to be focused, assessing only selected specific aspects of actual and potential need.

Other professionals, including GPs, hospital-based staff or social workers, normally identify the need for DN intervention. Therefore, their understanding of the role of the DN is crucial in relation to referring patients who would benefit from DN assessment and intervention. Barclay et al (1999) examined the differing priorities of 167 GPs and 96 DNs for palliative care services in the Cambridge area by a postal survey. The response rates were high with 84% (141) GPs and 90% (86) DNs replying. The results of this study indicated that, whilst caring for patients and families with palliative care needs was central to the role of both GPs and DNs, the two professional groups rated the essential components of palliative care services at home differently.

The DNs placed more emphasis on services such as those provided by Marie Curie Nurses and other systems of support including day and respite care. The GPs rated the support of specialist doctors and nurses in relation to symptom control as a priority. These findings suggest that the DNs were more concerned with the day to day support of the patient and family rather than decision-making in relation to symptom control. Whilst these findings are indicative of the role of these two professional groups, if GPs are responsible for referring patients with advanced disease to the DN service, their perceptions of the DN role and of those needs of the patient with which the DN can assist, are important.

Cartwright (1991) identified a discrepancy between the perceptions of GPs and DNs in relation to when patients with palliative care needs were referred to the DN service. Of the GP's, 86% thought they referred patients to the DN for advice and support before physical-nursing care was required. However, almost half of the DNs (48%) stated that the GPs did not refer patients early enough for them to offer support and advice to the patient and carer.

To date, there is limited understanding of the processes and knowledge involved in community nursing assessment. In order to establish which problems and needs require intervention, the DN has to distinguish between relevant and non-relevant information and interpret the available information. The influence of the personal values of those involved in the assessment process is noteworthy. How other professionals, including GPs and Social Workers who are involved in identifying the need for DN intervention, perceive the role of the DN is crucial to appropriate referral to the DN service.

2.2.3 Summary – needs assessment

This section of the review has presented different perceptions of need and has confirmed that although the concept is addressed in the literature, defining need is complex. In district nursing needs assessment, two main factors appear to influence this complexity. The influence of the **values** and perceptions of those involved in the needs assessment process - the patient and/or family, the DN and other health care professionals - could result in conflicting views as to what needs exist and whether these could/should be met by the DN service. Additionally, evidence would suggest that practitioners may continue to carry out service-based rather than needs led-assessments due to on-going **resource constraints**. These resources may vary in different geographical areas and at different times of the year. For example, some areas will have better access to specialist services such as palliative or

paediatric care specialists than others. Personal experience confirms that during the year the availability of resources can vary due to budgetary pressures. These factors are likely to influence the process of identifying and meeting needs.

Over the last 30 years nurse theorists have promoted the use of systematic approaches to needs assessment in clinical practice, for example the nursing process and models of nursing despite a lack of evidence to support this practice. It could be argued that if different nurses each assessed the same patient utilising such approaches that they should each arrive at the same conclusions. However, there exists no recognised framework for DN assessment.

The available evidence presents a confused picture as to how well the DN service meets individual need. More recent research suggests that although DNs may be selective about which aspects of patient need they explore at the first visit, they generally cover a range of physical and psychosocial needs (Bryans 1998, Worth 1999).

Assessment is described as a complex process. Attempting to uncover the knowledge underpinning assessment practice has been noted as challenging for empirical research (Bryans and McIntosh 2000). Practitioners bring their prior knowledge, professional artistry and skills in problem recognition and problem solving to the assessment process (Bryans and McIntosh 1996; Ross and Mackenzie 1996). The next section of the review has its focus on an exploration of the nature of knowledge in the discipline of nursing and the implications for district nursing assessment practice.

2.3 Introduction: The nature of knowledge in the discipline of nursing

“It is the general conception of any field of enquiry that ultimately determines the kind of knowledge that field aims to develop as well as the manner in which that knowledge is to be organised, tested and applied. Such an understanding involves critical attention to the question of what it means to know and what kinds of knowledge are held to be of most value in the discipline of nursing” (Carper 1978 Pg. 13).

Interest in what constitutes the essence of nursing knowledge has developed steadily in the United Kingdom since the 1960’s stimulated by the growth in undergraduate and postgraduate programmes of education and in nursing research. These developments have drawn widely upon the knowledge and research methods of the physical sciences, social sciences, arts and humanities. Debate about the existence and nature of nursing knowledge

continues to centre around the need for knowledge which provides practitioners with both a theoretical framework **and** knowledge that can be used in practice (Chinn and Kramer 1999). Furthermore, the increasing emphasis on evidence based practice raises important questions about the knowledge base required by nurses (National Health Service Management Executive 1994; Kennedy 1998; Wilson- Barnett 1998).

This section of the literature review explores the nature of knowledge in nursing. It is suggested that nurses working in the community require a knowledge base that encompasses 'knowing that' or scientific knowledge, which enables professional action and 'knowing how', which cannot be separated from action and may be regarded as personal or experiential knowledge (Eraut 1994). To date, much of the knowledge required to support the evidence base of nursing practice, including district nursing practice, is relatively unexplored. In this study, the problems associated with the examination of knowledge in district nursing practice, which is largely hidden in the skill and professional artistry of the practitioner (McIntosh 1996; Bryans and McIntosh 2000), are revealed.

2.3.1 Developments in district nurse education

With increased attention being focused on the anticipated rise in demand for community services, the nature and scope of education in this field of nursing becomes of central concern. This raises important questions about the knowledge base required for district nursing practice. Education for district nurses has developed significantly since the inception of the NHS in 1948. The establishment of the Panel of Assessors and courses leading to the National Certificate of District Nursing (which many DNs achieved through the Queen's Nursing Institute), was crucial to the development of DN education programmes.

The National Boards' for Nursing, Midwifery and Health Visiting, established in 1983, later assumed responsibility for district nurse education, which was then delivered in Colleges, Polytechnics and Universities. DN education programmes subsequently developed to diploma level and included supervised practice as the scope of primary health care widened (Baly 1995).

Policy documents have acknowledged that community nurses need a sound knowledge base and appropriate skills in order to meet new challenges resulting from policy, demographic and epidemiological changes. Education for community nursing has undergone a period of profound change. Project 2000 programmes of pre-registration nurse education have provided baseline preparation for practice in the community (UKCC 1986).

The Post Registration Education and Practice Report (PREP) sets out UKCC standards for specialist practice and requirements for maintaining registration (UKCC 1994a; UKCC 1994b). PREP cites seven specialist areas of community practice for which programmes of study should be at degree level. These are; Public Health Nursing (Health Visiting), Community Nursing in the Home (District Nursing), Community Psychiatric Nursing, Community Mental Handicap Nursing, General Practice Nursing, School Nursing and Community Paediatric Nursing. Specialist education programmes were required to meet UKCC standards by September 1998. These programmes address core and specialist skills and knowledge in relation to clinical nursing practice, care and programme management, clinical practice leadership and clinical practice development (UKCC 1994a; UKCC 1994b).

The standards and requirements in PREP emphasised the importance of decision-making and that the monitoring and improvement in standards of care are essential attributes of the specialist practitioner. The qualified DN is now generally required to assume more of a team leader/management role than in the past. New knowledge and skills are required to prepare her for this role. Nevertheless, despite significant developments in DN education over a long period of time, the research and evidence base for practice remains low.

2.3.2 Ways of knowing

Traditionally, nursing has followed the positivist research paradigm in the pursuit of academic credibility. There are now increasing attempts by nursing scholars to legitimise the knowledge derived from experience and practice rather than from scientific enquiry alone. It is important to explore these works in relation to district nursing practice, as, arguably, a significant proportion of the knowledge required for this area of practice lies within the practice of experienced district nurses (McIntosh 1996). Caring for patients and families who have care needs in the community requires a knowledge base that

encompasses the physical, psychosocial and spiritual aspects of care and a range of interpersonal skills.

The role of theory in nursing practice

Prior to a fuller exploration of the nature of nursing knowledge it is important to clarify the relationship between theory and knowledge. This relationship is often poorly defined and the terms may be used synonymously. Theory is generally held to be a system of abstract, explanatory concepts and ideas which:

“... orders knowledge in a descriptive, explanatory or predictive framework. It enables us to employ knowledge in order to describe the world, to explain it, and most importantly, to make predictions about it” (Rolfe 1998 Pg. 9).

Theory, therefore, has an important part to play in assessment by providing a framework for the process and by enabling the practitioner to interpret the information collected. However, basing practice on scientific theory and empirically derived knowledge alone has been reported as problematic for many practitioners who may be unconvinced of their relevance to every day practice (Reed and Ground 1997; Rolfe 1998; Marks-Maran 1999). Schön (1991) identified that for many practitioners, the ‘high ground’ of research-based theory has limited relevance to the ‘swampy lowlands’ of day-to-day practice.

Eraut (1994) has described theory as being both public and private. Public theories can be discussed and refined whilst private theories may be private versions of public theories or unique to the individual. Reflective practice (discussed in Section 2.3.6) has been recognised as one way of helping practitioners to identify, examine and extend their private theories and knowledge.

Assessment in district nursing practice involves an interaction with a patient and/or family in a complex, unpredictable and ever-changing environment, it is therefore likely that practitioners use a mix of public and private theories (Luker and Kenrick 1992). Bryans and McIntosh (2000) suggest that:

“...there are likely to be large areas of theoretical, procedural and values related knowledge which are currently either indistinct or completely invisible on the map of professional nursing knowledge” (Pg. 1245).

If practitioners do use a mix of public and private theories, coupled with knowledge which is multi-dimensional and implicit rather than explicit in nature this contributes to the difficulty in uncovering the nature of the knowledge involved in district nurse assessment practice. This section of the review aims to explore the relationship between ‘knowing that’, or scientific knowledge, which enables professional action and ‘knowing how’, or personal/experiential knowledge, which cannot be separated from action, within the context of district nursing practice.

Defining ‘knowing’

Knowing may be described as ‘having knowledge’, ‘reflecting knowledge’ or as a ‘personal, internal experience of cognition’ (Walker and Avant 1988). Knowledge can also represent the collective and accepted account of the world as known by its members (Chinn and Kramer 1999). A proportion of what nurses know is not necessarily available or accessible to other professionals, suggesting that nurses ‘know’ on an individual basis. However, as yet we have failed to make a significant amount of our individual knowledge accessible to others thereby restricting the development of a body of knowledge for nursing practice (Robinson and Vaughan 1992).

The seminal work of Carper (1978) examined early nursing literature and named four fundamental ways of knowing in nursing – empirics, the science of nursing; ethics, the component of moral knowledge in nursing; aesthetics, the art of nursing; and personal knowing in nursing. These have remained the fundamental ways of knowing reflected in nursing’s current literature.

Carper (1978) claims that nursing knowledge, which acts as a rationale for nursing practice, has patterns, forms and structures that can be understood. Carper’s work was significant as it named knowledge forms in addition to empirical, scientifically based knowledge. White reviewed, critiqued and updated the work of Carper and proposed the addition of a fifth pattern of knowing, socio-political knowing (White 1995).

2.3.3 Empirics - the science of nursing

Carper (1978) described empirical knowledge as:

“...Knowledge that is systematically organised into general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing... The first fundamental pattern of knowing in nursing is empirical, factual, descriptive and ultimately aimed at developing abstract theoretical explanations. It is exemplary, discursively formulated and publicly verifiable” (Carper 1978 Pg. 15).

This form of knowledge is the pattern most closely associated with traditional science and is based on the assumption that what is known is accessible through the senses and can be observed and verified by others. It has been suggested that scientific enquiry is the most sophisticated method of acquiring knowledge developed by humans and that in problem solving is more reliable than tradition, authority, experience or trial and error (Polit and Hungler 1993).

Scientific enquiry involves rigorous methods of data collection, analysis and interpretation of results. Empirics are expressed as laws, theories and principles that have general applicability. Traditionally, science has been viewed as a superior form of knowledge with high academic status and this has resulted in increased emphasis on scientific research in nursing. The value placed on scientific knowledge in underpinning nursing practice, has increased the emphasis on research/evidence based practice, hard facts and objectivity (National Health Service Management Executive 1994; Reed and Ground 1997; Wilson-Barnett 1998).

During the last decade there has been debate about the ability of scientific or propositional (textbook) knowledge alone to account for the complexities of real life practice. Clearly nurses need to have empirical knowledge and Nolan et al (1998) warn against dismissing the contribution of scientific knowledge from other disciplines to nursing practice. Shaw (1993) also reminds us that rejecting positivist/quantitative research methods would be an error as the empirical methods have advanced medical science and informed the practice of nursing. Empirical knowledge (knowing that) is available in relation to many areas of practice including wound management, controlling distressing symptoms in patients with advanced disease, managing continence and maintaining skin integrity. The introduction of Nurse Prescribing means that DNs also require knowledge relating to pharmacology and therapeutics (While and Rees 1993).

It has been highlighted that an individual can build up a large bank of facts, theories and ideas about a subject, person or thing without the experience of that subject, person or thing (Burnard 1996). Nursing, however is a practice-based discipline and it is expected that knowledge will be gained through experience in practice.

Schön described scientific knowledge as 'technical rationality' where scientific knowledge is generated by academics and then transmitted to students/practitioners who are expected to put it into action (Schön 1983; Schön 1987). Marks-Maran & Rose (1997) suggest two assumptions underpin this: firstly, that researched evidence is a superior form of knowledge and secondly, that there is always evidence to support practice decisions. These assumptions are challenged by some authors who argue that in reality science often may produce irrelevant abstractions which cannot inform practice (Greenwood 1984; Miller 1985).

It is argued that scientific enquiry in nursing is viewed as the process by which nursing theory is generated (Miller 1985). Counter to this is the position that empirics cannot encompass all research-based knowing (White 1995) and that empiricism could be incompatible with nursing's humanistic and holistic aims (Fawcett 1984).

A decade after Carper's work, Jacobs-Kramer and Chinn (1988) interpreted and extended Carper's framework to facilitate integration of empirical knowing into clinical practice. They suggested that this form of knowledge included problem solving and logical reasoning.

Carper's work has drawn attention to the fact that, currently, nurses and nursing need and depend upon additional knowledge to that provided by empirical science. This recognition has been crucial to the development of nursing knowledge (Chinn 1994). White (1995), in her review of Carper's work, argued for the definition of the empirical pattern of knowing to be modified to include the naturalist, relativist ontological positions of knowledge development using methods such as phenomenology and ethnography. She argues that through such interpretation and description, context-embedded stories would enrich understanding.

Shaw (1993), who identified the need for a period of theory development and refinement, aligns with White's argument that nursing needs to draw from a rich tapestry of theoretical perspectives and research methodologies for knowledge development to encompass the practice elements of nursing. Chinn and Kramer (1999) stated that the science of nursing had broadened to include inductive means of generating nursing theory although they offer little evidence by way of examples to support this claim. The positivist, scientific paradigm has been prominent within the development of nursing knowledge and the requirement for the development of a knowledge based NHS and for evidence based practice may be viewed as reinforcing the prominence of this paradigm (National Health Service Management Executive 1994).

To an extent the debate in relation to nursing knowledge has become polarised between the merits of knowledge derived from scientific research and that which exists in practice. The practice elements of nursing have traditionally been viewed as the "art" of nursing practice, the aesthetic pattern of knowing, which are now explored.

2.3.4 Aesthetics - the art of nursing

Carper acknowledged the emphasis on the development of nursing as a science and the reluctance to acknowledge the elements of knowing in nursing which are not gained as the result of empirical enquiry. Carper viewed this as a significant error and although she did not offer a definition of the art of nursing she argued that there are recognisable aspects of the concept (Carper 1978). These included the expressive and technical skills of nursing and the unity between an action taking place and its result. For example, whilst a nurse setting up a syringe driver for a patient requires competence in the task, the espousal of holistic care recognises the need for a practitioner who can identify and meet the key psychological and social aspects of care (Kennedy 1998). Gaining a fuller understanding of this pattern of knowing involves exploration of the communication strategies used by nurses (White 1995).

Several writers highlight the wealth of untapped knowledge embedded in the expert practice of clinicians (Hampton 1994; Meerabeau 1995; Benner et al. 1996). They suggest that expertise is correlated more closely with the artistic rather than the empirical basis of nursing. The increasing interest in this knowledge pattern with reference to nursing has

been particularly important in exploring the concept of expert practice and expert nurses who are able to perceive situations as a whole (Benner 1984).

White (1995) suggested that if experience was a fundamental component of the aesthetic dimension of practice then this must include exploration of the context-specific experiences of nurses. The influence of the context, the patient's home circumstances, on assessment practice is particularly important in district nursing. Other writers have also suggested that the key to uncovering the 'art' of nursing lies in the adoption of systematic research approaches that include observation of clinical practice combined with in-depth explanations by practitioners about their practice (Meerabeau 1995; McIntosh 1996).

Benner's 1984 work was descriptive research based on a dialogue with nurses. Using the "Dreyfus Model of Skill Acquisition" she explored expertise and the differences in practice between experienced and less experienced nurses. The Dreyfus Model proposes that in acquiring expertise relating to a particular field, people pass through five stages of qualitatively different perceptions that inform how they undertake a task and/or reach a decision.

This model highlights how expertise is developed in three dimensions:

- a shift from relying on abstract principles to perceive and interpret problems, towards using past experience as a base for judgement
- a change from understanding parts of a situation to an immediate grasp of the whole situation
- a shift from being detached and outside the situation to being involved.

Benner (1984) identified five levels of competency in clinical nursing practice - novice, advanced beginner, competent, proficient and expert. Benner argued that expertise develops through a process of comparing similar and dissimilar clinical situations and the expert bases understanding of clinical situations upon past experience. Benner saw expertise as an amalgam of theoretical and practical knowledge. She argued that expert nurses test and refine theoretical and practical knowledge during their practice. However, Benner did not explore how practitioners can ensure that the new knowledge they may generate through this process can be tested and/or explained to others.

The work of Benner was significant, as it was the first major attempt to explore the knowledge embedded in the practice of experienced nurses. There have been some criticisms of Benner's work including claims that it was methodologically flawed. The participants in Benner's study were 'expert' subjects who were identified by their peers. However, the criteria by which these expert nurses were identified or measured were not explicit (English 1993). Benner also used a significant number of self-reported narratives from the nurses as the basis of her work. Reliance on the recall of critical incidents by the study participants may have influenced the results as such methods may be subject to the influence of memory and the effects of hindsight bias. Although Benner's study included observation of some of the participants it was not clear how the observations were utilised in the follow up interviews or the data analysis and reporting. However, Benner's work has been influential in nursing and has opened up significant debates about the nature of expertise, expert practice and the philosophy of knowledge (Paley 1996).

In addition to the work of Benner, MacLeod has made a significant contribution to the concepts of experience and expertise in nursing practice (MacLeod 1996). Macleod studied ten "excellent, experienced" surgical ward sisters in two Scottish teaching hospitals. MacLeod acknowledged that her work "sits closely to Benner's work" (p122) but she found quite a different pattern to the practices described by Benner. Rather than identify competencies, roles and domains of practice, she analysed the sisters' experience in relation to the stay of the patient and the day-to-day running of the ward. MacLeod stated that three distinct yet inextricably linked processes, *noticing*, *understanding* and *acting*, characterised how experienced nurses practised nursing. The nurse notices salient features in the context, understands their meaning and acts in caring for the patient (Macleod 1996). Macleod, in studying expertise, undertook periods of participant observation, combined with in-depth interviews, methods also selected and found to be useful in this study of DN practice.

2.3.5 Personal (practical, practitioner, experiential) knowledge

The complex and diverse nature of practitioners' knowledge base is assumed to be derived from a range of sources including experience of cases and problems in practice, working with colleagues/role models, personal experiences, formal theories and public knowledge (Eraut 1994; Rolfe 1998). It is clear from even a cursory glance at the literature in relation to nursing knowledge that many terms are used, often interchangeably. Personal

knowledge is referred to by a range of terms including practical, practitioner, tacit, intuitive, experiential or “know how” knowledge or professional artistry.

Personal knowledge is currently linked to know-how in everyday practice situations, integral to everyday action and gained from the experience of professional practice (Benner 1984; Rolfe 1998). For example, knowing how to deal with a grieving relative is demonstrated in the actions of the nurse. As identified above, Carper viewed the art of nursing as the unity between an action-taking place and its result. Assuming that the actions of the nurse are based on some form of knowledge, this description seems to have parallels with definitions of personal/experiential knowledge as ‘know how’ in everyday practice. However, the distinctions being made between the many terms being used by a number of authors are not clear and this lack of clarity complicates the exploration of the knowledge underpinning a practice based activity such as assessment.

Personal knowledge clearly aligns with the artistic components of nursing practice and the distinction between aesthetic and personal knowledge may be an arbitrary one which does little to enhance understanding within the profession. Some writers have also differentiated between personal and experiential knowledge (Rolfe 1998). Again it is questionable whether this separation is helpful, as the distinctions between these two types of knowledge are unclear.

Rolfe (1998) for example, described experiential knowledge as that which has accumulated from the experience of a number of clinical encounters and personal knowledge as knowledge derived from experience of individual clinical situations. As both experiential and personal knowledge are unique to the experience of the individual, he would seem to suggest that experiential knowledge is the sum total of personal knowledge. However, it is not clear from Rolfe’s discussion at what stage personal knowledge is transformed to experiential knowledge. Additionally, experience, by definition, is ongoing and cumulative.

The seminal work of Benner provided the first extensive and systematic exploration of personal knowledge in nursing (Benner used the term practical knowledge). Benner (1984) argued that personal/practical knowledge was derived from experience of the day-to-day caring for patients. She suggested this form of knowledge was tacit, known to the

individual, but not always capable of being explicitly described and may be complementary to intuition.

A qualified nurse caring for a patient who is dying is expected to have knowledge of the physical, psychological and spiritual needs of the patient. However, Benner claims it is the 'knowing how' that helps the nurse to act in practice. For example, if a nurse requires to comfort a distressed patient or relative, or answer difficult questions appropriately she must understand the impact of advanced illness on the patient and relative, know what measures might alleviate their distress and also know how to implement these. The nurse may be able to explain theories of anticipatory loss and explain a rationale for appropriate interventions but may find it difficult to explain how she actually relieved the distress. This example illustrates the difficulties in separating the intellectual, cognitive and empirically derived elements of nursing knowledge from care giving activities (Reed and Ground 1997).

The original purpose of Benner's (1984) study of 1200 nurses in San Francisco, was to develop methods of evaluating the clinical skills of nurses for participating nursing schools and hospitals. Critical incidents of nursing practice provided by the nurses were examined. Additionally, 21 pairs of novice nurses and their experienced nurse preceptors were studied to determine the differences in clinical performance and appraisal of nursing care situations in which both were involved. A further 51 experienced clinical nurses, 11 new graduates and 5 senior nursing students were interviewed and/or observed in order to describe characteristics of nursing performance at different stages of skill acquisition. Data were analysed using an interpretative approach and six areas of practical knowledge were identified:

Graded qualitative distinctions – these involve the nurse being able to understand and prioritise the issues that are of concern for a particular patient at that moment in time

Common meanings - these evolve over time and are developed by nurses working in similar areas. They are part of the language and tradition of nurses in particular clinical areas

Assumptions, expectations and sets - these are contextual, narrative accounts of nursing practice which set out the assumptions and expectations about the progress of the patient which underlie nursing assessment and actions

Paradigm cases - nurses store and retain vivid memories of significant events which may change their preconceptions and prior knowledge. Benner (1984) defines the paradigm case as:

"A clinical episode that altered one's way of understanding and perceiving future clinical situations. These cases stand out in the clinician's mind; they are reference points in their current clinical practice" (Pg.296).

Maxims - cryptic instructions passed on by experts that can only be understood by someone with enough skill and practical know-how

Unplanned practices - the nurse at the bedside is frequently asked to carry out a new treatment or procedure because the nurse is present when it needs to be done. Consequently, perceptions and clinical judgements are altered and nurses become experts with resultant 'know-how' knowledge.

The above categories may illuminate the different ways in which practical knowledge can be developed, used and demonstrated. However, the distinctions between the categories appear blurred. This raises questions as to the utility of such an approach toward enhancing understanding of the knowledge underpinning nursing practice. Uncovering the unity between the intellectual component of nursing practice and the physical activities of caring seems to demand an interpretative approach where the relationship between context and meaning are retained (Macleod 1996; Reed and Ground 1997).

Benner (1984) does however draw attention to the wealth of untapped knowledge embedded in the clinical nursing practice of expert nurses. She warns that this knowledge base will not develop or gain recognition unless nurses systematically record for themselves and others what they learn from their own experience.

Reference to **tacit** (or unspoken) knowledge in nursing literature is normally linked to personal knowledge and to expert practitioners who view situations holistically and draw on past concrete experience. Meerabeau states:

“Tacit knowing is when we know something only by relying on our awareness of it for attending to a second activity; it is the hallmark of skilled practice, but also a feature of many everyday activities” (Meerabeau 1995 Pg. 33).

If “professional artistry”, a term used by Meerabeau to describe tacit knowledge consists of private knowledge which cannot be made explicit, then many aspects of a profession can only be learned through experience and close association with expert practitioners. Working with “role models” or expert practitioners is a feature of nurse education and continues to be a subject of debate in the nursing profession (UKCC 1994a).

Intuition, as a feature of expert practice, has received attention in nursing literature (Gerrity 1987). The implicit nature of the knowledge base on which much nursing practice is based and the association of intuition to expertise have intensified this attention (Easen and Wilcockson 1996). Benner (1984) has suggested that expertise, which cannot be explained, indicates intuitive knowledge. Intuition, as a form of expertise, may be attractive to nurses as it can account for the experience they value so highly (Luker and Kenrick 1992).

Definitions illustrate the confusion between **intuition as a mode of cognition** (process) and/or **intuition as a type of knowledge** (content). For example, Benner and Tanner described intuition as understanding without a rationale, which could be interpreted as either a mode of cognition or type of knowledge (Benner and Tanner 1987). Bastick argued that intuition was the most perfect form of human thought (mode of cognition) (Bastik 1982). Intuition to Schrader and Fischer was ‘immediate knowledge of something without the conscious use of reason’ (type of knowledge) (Schrader and Fischer 1987 Pg. 47).

Intuition as a mode of cognition involves knowing and informs the actions of the nurse. If intuition is viewed as a mode of thought/cognition then the processes need to be examined. As a form of knowledge, intuition may provide additional information to inform decision-making (Young 1997). If intuition is viewed as a form of knowledge then the nature of that knowledge and how it is used in practice needs to be examined. Easen and Wilcockson (1996) describe intuition as a ‘black box’ and suggested that “...intuition is an irrational process but with a rational basis” (Pg. 672). Intuition, they suggest, is derived from past decision-making and experience and is based on appropriate knowledge and the ability to

recognise patterns in the presenting problem. Whilst this description is representative of the debate that exists in relation to intuition, it does not help to explain intuition in professional nursing practice.

Marks-Maran (1999) argues that nursing experience that has not fitted into the positivist, scientific paradigm has been undervalued and frequently completely ignored. She suggested that this has led to intuition in nursing being undervalued and the emphasis on evidence based practice can only continue this trend if a limited view of the concept of evidence applies.

There are inherent difficulties in researching intuition as once a nurse tries to explain what she is thinking and why, it forces her to recall and analyse the cognitive processes involved. Miller (1995) developed an Intuitiveness Instrument, as a means to 'quantify' the construction of intuition. Five characteristics of the intuitive nurse are outlined:

1. Willing to act on intuition
2. A skilled innovative clinician
3. Having a spiritual connection in interactions with clients
4. Interested in the abstract
5. A risk taker

(Miller 1995 Pg. 314).

It is not clear how these characteristics can be measured. If intuition is independent of conscious reasoning or comprises a largely invisible knowledge base then, arguably, attempting to construct and quantify the components of intuition is difficult, if not impossible. There are dangers inherent in nurses accepting that practice based on tacit and intuitive knowledge is always 'best' practice. It is unreasonable to assume that the practice of experienced nurses is *always* of good quality. If we accept there is important knowledge embedded in the practice of experienced clinicians, the potential of reflective practice as a vehicle for uncovering and learning about these ways of knowing is considerable.

In summary, personal knowledge in nursing is assumed to have a significant experiential component and is closely associated with intuition and expertise. Such knowledge has been associated with a highly individual knowledge base that is difficult or even impossible to explain, a knowledge base that cannot be "taught" easily and a consensus that this type of

knowledge is an enormous and largely untapped resource (Benner 1984; Easen and Wilcockson 1996). Practitioners seem to have difficulty articulating how they use knowledge in practice. This complicates the exploration of assessment practice which is likely to comprise an amalgam of private and formal theories (Worth 1999).

Reflective Practice

Interest in reflective practice as a means for nurses to explore and expand their knowledge has gathered momentum in practice and education. As a concept, however, reflection has not been rigorously tested or validated (Palmer et al. 1994). The work of Schön has been influential in the education of many professionals including nurses and teachers. Schön suggested that the limitations of technical rationality, a pure, applied science view of professional practice, could be overcome by creating an epistemology of practice where technical problem solving exists within a broader framework of reflective practice. The two elements were described as reflection in action and reflection on action (Schön 1987).

Reflection in action, is based on “knowing in action” and is the tacit, intuitive moment when in the midst of an action we know what is the right or wrong thing to do and consequently change our course of actions (Schön 1991). Practitioners undertake reflection in action in the midst of undertaking a professional activity. The individual asks him/herself, consciously or subconsciously, key questions in the midst of action;

- What am I noticing here and what does it mean?
- What judgements am I making and by what criteria am I making them?
- What am I doing and why?
- Is there an alternative course of action other than the one I am taking?

(Marks-Maran and Rose 1997 Pg. 114).

These questions could potentially provide nurses with a useful framework with which to challenge and extend their thinking. However, whether an individual will engage consciously in this activity in the midst of an assessment visit is questionable.

Reflection on action involves looking back on a past experience and creating new understandings from the analysis of the outcomes of the original action (Greenwood 1993). Models and theories of experiential learning have permeated nursing literature and

curricula. Kolb's (1984) experiential learning model is widely used in nursing and central to this model is the belief that experience is where learning begins and ends. Experience is viewed as concrete, happening to, and involving an individual. Kolb argues that experience has to be grasped and transformed by the individual. The process by which this can be achieved is depicted by a four- stage cycle which begins with a concrete experience as the basis for observation and reflection. These observations and reflections are formed into new ideas which can produce new implications for future action. The last stage of the cycle is the application of new ideas into future practice where the cycle of reflection may commence again (Kolb 1984).

Both reflection in action and reflection on action are proposed as ways in which practitioners create new understandings of knowledge in practice. Newman claims that the work of Schön has been widely accepted, but with limited critical appraisal of the concepts (Newman 1999). In particular, the ability of practitioners to reflect in the midst of action would benefit from further exploration.

In summary, regarding practical knowledge, two key points can be made: the debate surrounding the nature of the personal or practical knowledge underpinning the practice of nursing is complex and at early stages of development. Carper states that personal knowing...

"... is the most problematic, the most difficult to master and teach. At the same time, it is perhaps the pattern most essential to understanding the meaning of health in terms of individuals well being" (Carper 1978 Pg. 18).

Secondly, Meerabeau (1995) states that recognition and promotion of practical knowledge as a legitimate way of informing practice is essential if practitioners are to defend their practice other than in terms of tasks.

2.3.6 Ethics - the moral knowledge of nursing

Practitioners are faced with daily choices and decisions about morally right and wrong actions in the care and treatment of illness and in the promotion of health. The ethical dimensions of knowing are employed by the nurse to reach a decision that informs subsequent actions. Carper acknowledged the importance of practitioners having knowledge of ethical norms and codes and outlined the scope of knowledge required thus:

“Knowledge of morality in nursing goes simply beyond knowing the ethical codes of the discipline. It includes all voluntary actions that are deliberate and subject to the judgement of right and wrong” (Carper 1978 Pg. 20).

Carper cautions nurses on the complexity of ethical issues in modern practice by reminding them that choice must be considered in relation to the context in which actions will take place. Morality is about notions of right and wrong, good, bad and moral ideals in nursing are reflected in the Code of Professional Conduct (UKCC 1992). This Code sets out how the nursing profession expects its members to behave and is based on the concepts of service to people and respect for persons. Carper (1978) suggested that moral dilemmas arise for nurses in situations of ambiguity and uncertainty where traditional codes and theories offer little help and could result in further confusion. She focuses the ethical component around the concept of obligation or the ‘oughts’ or ‘shoulds’ of life.

Whilst the Code of Professional Conduct can provide some guidance to nurses, such guidance can only be partial. The values an individual may hold to be important are crucial in shaping their practice. Values are considered to be one aspect of knowledge in their own right. However, values are often invisible and the impact of individually held values on individual practice is difficult to discern (Chinn and Kramer 1999).

Sarvimaki (1995) suggests that moral knowledge is a combination of theoretical-ethical, personal, situational, and action knowledge. Theoretical-ethical knowledge forms a component of nursing curricula and can provide nurses with a theoretical framework for ethical reflection. However, in the practice of nursing the nurse will demonstrate some of her moral knowledge through action. Dilemmas may arise where a number of alternatives for actions are possible but there are no clear-cut solutions for action (Sarvimaki 1995).

For example, when a patient is near the end of life, how does the DN assess and decide which nursing interventions are appropriate? Should the patient be moved for pressure area care? What are appropriate interventions for distressing symptoms? A nurse may theoretically know what actions to take to prevent a breakdown in skin integrity but has to balance the considerable risk of causing discomfort, with the potential benefits of her actions.

2.3.7 Socio-political knowing - the context of nursing

White's (1995) fifth and additional pattern of knowing encompasses the socio-political environment and people's interaction with it. She suggests that this pattern of knowing broadens the perspective of nurses making them question previously taken-for-granted assumptions in relation to practice, the profession, and health policies (White 1995). Health policies highlight the potential contribution to healthcare planning that is expected of nurses (The Scottish Office Department of Health 1996; The Scottish Office Department of Health 1997) and new knowledge and skills may be required for this role.

2.3.8 Discussion and implications for district nursing

The debate surrounding ways of knowing in nursing is complex and at relatively early stages of exploration. The literature tends to separate theoretical and practical knowledge. However, the relationship between these two types of knowledge is poorly defined and complex due to the difficulties in separating practical skills from the intellectual, cognitive and empirically derived elements of knowledge.

The influential work of Carper has provided an analytical framework from which most of the work exploring nursing knowledge has evolved. In particular, Carper's work has stimulated interest in forms of nursing knowledge other than those that are the result of empirical enquiry. The work of Benner (1984) and Schön (1987, 1991) has been particularly important in acknowledging the tacit, intuitive elements of nursing knowledge and the potential of reflective practice to provide important insights into the nature of knowledge embedded within clinical nursing practice. A recurring theme in literature is the suggested need to reclaim practitioner knowledge.

Whilst Carper's format remains the fundamental analytical framework, it is proposed that attempts to categorise knowledge in this way may produce meaningless classifications. This is due, in part, to the difficulties involved in the exploration of personal or experiential knowledge. There are inherent difficulties in separating the intellectual component of practice from caring activities. Exploration of the connections between 'knowing that' or theoretical knowledge on which action may be based, and 'knowing

how' or practical knowledge which cannot be separated from action, may help nurses to uncover the knowledge embedded in clinical practice.

Reed and Ground (1997) suggest that nursing has never been considered to be either the mindless carrying out of physical tasks or purely an academic reflection on the phenomena of illness. Yet within nursing, the processes of thinking and doing have been considered separate activities, related but fundamentally different. They suggest that all knowledge is provisional and that the value base of knowledge will constantly change. By treating all knowledge as provisional and certainty as relative, the relationship between theoretical and practical knowledge can be more readily examined and revised.

Luker and Kenrick (1992), in exploring the sources of influence on the decisions of DNs, found that the DNs were unable to articulate the sources of their knowledge and that a large proportion of their practice was based on experiential knowledge. The DNs themselves, however, considered that a significant proportion of their work required a scientific basis. Luker and Kenrick (1992) suggest this may be because experienced nurses have developed an integrated knowledge base that does not differentiate between knowledge, experience and science. Macleod (1996) also found, in her exploration of experienced ward sisters, that she was unable to discern their theoretical knowledge from observations of their practice or from the sisters' own accounts of their practice. Macleod also suggested that abstract theoretical knowledge had become part of knowing in practice. It is noteworthy that both these studies were conducted in the real world of practice and that the research approaches lay within the interpretative paradigm, the paradigm selected for this study

Uncovering the knowledge, which informs assessment practice, is likely to be a complex task. As a guest in the home of the patient, the DN has to negotiate with the patient and/or family appropriate and acceptable interventions to meet identified needs in a relationship which may span several years. Assessment, therefore, needs to be individualised to the patient and take cognisance of the psychosocial elements of the situation. Therefore, district nurses need to know how to assess a patient in a complex, unpredictable and ever-changing environment. The DN is likely to have a conceptual framework, consisting of private and public theories (Eraut 1994), to guide the assessment process and knowing what information to collect and how to interpret the information represents an important part of the assessment process. Assessment is a particularly challenging interaction in DN

practice and as such represents an opportunity to explore some aspects of the knowledge base of the DN. However, methodologically this exploration is challenging because of the difficulties associated with exploring cognitive and affective processes.

Having explored the nature of knowledge in the discipline of nursing and the implications for DN practice, the next section of the review explores the two main perspectives of decision-making: intuitive and analytical decision-making, in relation to nursing practice. The discussion is then focused on the implications of the findings from the review for district nursing practice.

2.4 Introduction: Clinical judgement and decision-making

Much of the early work on clinical decision-making originates from the medical profession (Elstein et al. 1978; Dowie and Elstein 1988). It has been suggested that the nursing profession needs a better understanding of how expert and experienced nurses make decisions (Orme and Maggs 1993). However, the literature on clinical decision-making within nursing is relatively new and much of it emanates from North America.

Professional documents (UKCC 1986; UKCC 1994a) and studies of the work and learning of newly qualified and experienced nurses (Runciman et al. 1998; Walker et al. 1998) note that practitioners require the ability to perform a range of cognitive skills; for example, ability to evaluate, discriminate, interpret and critically analyse and appraise aspects of their role. These cognitive skills underpin professional judgement and decision-making in practice. Consequently, there is an increasing interest in and need to explore the nature of professional judgement and decision-making in nursing practice. Harbison has argued for the inclusion of clinical decision-making theory in nursing curricula (Harbison 1991).

2.4.1 Perspectives on decision-making

Decision-making is a cognitive and often complex process, characterised by the selection, discrimination and synthesis of information which leads to action, or to the decision not to act. Health professionals are accountable for the decisions they make in their professional practice (UKCC 1992). Nursing curricula at pre and post-registration levels embrace a wide knowledge base derived from a variety of disciplines and a range of practical and technical skills. For example, a qualified nurse caring for a dying patient and his family is

expected to combine knowledge of the physical, psychological and spiritual consequences of advanced illness with her skill in delivering appropriate care. However, judgement processes require the nurse to analyse possible responses to questions like “when am I going to die” or “am I going to get better nurse”, or how to manage distressing symptoms appropriately. Therefore, the way in which the nurse decides to act may have a profound effect on the quality of care patients receive.

Clinical practice is driven by decisions and caring for patients and families involves a continuous sequence of decisions that may vary from the simple to the complex (Thomas et al. 1991). However, the processes by which decisions are reached are seldom consciously considered and discussed and there appears to be an irrational assumption within the nursing profession that increased knowledge and experience will result in *good* professional decision-making (Thomas et al. 1991; Kissinger 1998; Rolfe 1998).

Baumann and Deber (1989) define decision-making as making a choice;

“...among a number of possible alternatives often involving trade-offs among the values given to different outcomes” (Baumann and Deber 1989 Pg. 67).

This definition suggests that decisions in nursing practice may be influenced by a number of variables and that decision-making has a moral dimension. In the nurse-patient relationship, an important question facing nurses is whose values and trade-offs are reflected in the decisions made. Problems may arise if there is conflict between the values of the nurse and the patient and/or family. Additionally, in many situations in the community there are a number of alternative courses of action which could be taken (Bryans and McIntosh 1996) and therefore the patient should be involved in the decision-making process.

Throughout the literature the terms judgement and decision-making are used interchangeably which can be confusing. For the purposes of this study the terms are defined as follows; judgement is the **process** of weighting or estimating the possibilities (Schaefer 1974) and a decision is the **outcome** that leads to the action or a conclusion not to act (Thomas et al. 1991).

There are a number of positions from which to consider clinical decisions. However, the two main perspectives can be divided into 'intuitive' and 'analytical' thought and decision-making (Harbison 1991).

Intuitive and analytical thought

Hamm (1988) compares intuitive and analytical thought. Intuitive thought is:

".... rapid, unconscious data processing that combines the available information by averaging it, has low consistency and is moderately accurate.... Analytical thought is slow, conscious and consistent: it is usually quite accurate and is likely to combine information using organising principles more complicated than simple averaging.... most thinking is neither purely intuitive or analytical but lies somewhere in between" (Hamm 1988 Pg. 82).

Hammond's (cited in Hamm 1988) 'cognitive continuum' suggests that the catalyst for the mode of cognition used is dependent upon the nature of the cognitive task to be undertaken. This theory outlines six modes of cognition or practice ranging from intuition to analysis, which can be employed in judgement. These are; intuitive judgement, peer aided judgement, system-aided judgement, quasi experiment, controlled trial, and scientific experiment. Intuitive judgement is at the opposite end of the scale to scientific experimentation, which is considered to be the most rigorous form of analytical judgement.

Hammond's (1988) framework has been applied to both medical diagnosis and medical decision-making. It is based on the premise that different reasoning strategies can be used to ensure the quality of decision-making. For example, in making a diagnosis, the doctor may utilise knowledge gained through quasi experiment, controlled trials or scientific experiment to inform decision-making. In other decision-making tasks, intuitive judgement may be the most appropriate form of practice.

Nursing as a discipline has relied heavily on 'professional judgement' and/or 'intuitive judgement' rather than more analytical forms of decision-making (Benner 1984). It has been suggested that many health care practitioners operate towards the intuitive end of the continuum whilst researchers operate towards the analytical end (Dowie 1996). If intuitive thought is predominant and practitioners lack analytical insight to their decision-making processes then:

“If practitioners do not know how their current judgements and decisions reflect what they currently know or believe in relation to the subject of a piece of research, how can they modify them in the light of learning about the particular findings emerging from it? The answer is ‘not very easily, if at all’ ” (Dowie 1996 Pg. 10).

It could be argued that many of the tasks undertaken by nurses have more than one possible course of action outcome. For example, giving patients and families information requires the nurse to make judgements about what information would be appropriate to impart in this particular case. The nurse is therefore likely to adopt an individualised approach to decision-making.

Some aspects of practice may be more amenable to a more analytical approach to help the nurse determine the best possible course of action. For example, when assessing pain, a wound or other symptoms, a more systematic approach to assessment may be achieved by the use of relevant, validated assessment tools to guide the assessment process. These examples illustrate the possible relationship of the mode of cognition to the assessment task or the decision to be taken.

Benner’s (1984) work was based on the model of skill acquisition proposed by Dreyfus and Dreyfus (1980). This model proposes an alternative theory of cognition; that the key to cognition lies in the level of expertise of the decision-maker and not the task as outlined above. The model proposes that in order to acquire expertise in a particular area, the individual passes through five stages of qualitatively different modes of decision-making. Novices tend to use analytical thinking whereas the expert perceives the situation in an intuitive manner and bases decisions and actions on intuitive cognition (Dreyfus and Dreyfus 1980). In contrast to the views of Hammond, Benner (1984) argued that if experienced nurses were forced to adhere to formal rules and models, their performance might actually deteriorate. However, if the judgement of experienced nurses is invisible and cannot be subjected to scrutiny, this may reinforce beliefs that the decision-making of the expert is seldom wrong. It may also lead to automatic acceptance of decisions and limited questioning of current and accepted practices by practitioners.

2.4.2 Analytical judgement and decision-making

The rationalist perspective highlights the importance of analysing a situation in order to achieve rational and logical actions. Increasingly, nurses are expected to base their practice

on evidence and research and this perspective relates to this trend (Harbison 1991; National Health Service Management Executive 1993).

Theories of clinical decision-making are concerned with two main approaches; *prescriptive* approaches are concerned with prescribing how decisions ought to be made and *descriptive* models are concerned with describing how decisions are actually made (Thomas et al 1991). Examples of descriptive and prescriptive models of decision-making are now explored.

Descriptive models of decision-making

The nursing process (a decision-making model), as an example of a descriptive theory of decision-making was an attempt to promote analytical thinking in nursing. It has been suggested however, that the linear approach of the nursing process is not particularly well suited to the thinking required when care planning in nursing. Rather, the personal or practical knowledge of the nurse guides her judgement and subsequent decision-making (Jenny and Logan 1992; Ellis 1997; Fowler 1997).

The nursing process outlines the four stages the nurse needs to complete in care giving. However, the cognitive strategies required in nursing assessment, the first stage of the process, have received scant attention and assessment is normally equated simply with information gathering (Crow et al. 1995).

Clinical judgement has been more extensively studied in medicine than in nursing and the hypothetico-deductive approach employed by medical staff has been identified (Elstein and Bordage 1979). This descriptive model of decision-making has four stages. It differs from the nursing process as the cognitive strategies that doctors utilise in order to reach a diagnosis are identified:

The hypothetico-deductive approach:

- data collection - the process of gathering and collecting information
- hypothesis generation - the process of generating alternative formulations of the problem
- cue interpretation - the process of interpreting the evidence in light of these hypotheses

- hypothesis evaluation - the process of combining information to reach a diagnostic decision or judgement

There is some evidence to suggest that experienced nurses may also use this model of clinical reasoning although they are often unable to explicate it (Ellis 1997; Offredy 1998; Hallett et al. 2000). This information processing approach to decision-making involves selecting cues from the presenting situation and building up hypotheses of possible problems (Elstein et al. 1978). Very quickly the nurse will generate one or two working hypotheses which might explain the observed cues. The nurse will look for further cues to support or refute the hypotheses identified. Novice nurses tend to use the linear model of the nursing process by collecting all the data and then carrying out systematic analysis (Benner 1984), whereas the experienced nurse may use the hypothetico-deductive approach (Putzier et al. 1985; Offredy 1998).

There are difficulties associated with experienced nurses employing the hypothetico-deductive approach as they may use the hypothesis activated early in the nurse/patient encounter to direct the collection of further information. The nurse may overestimate the value of the information that appears to support her working hypothesis and disregard other information (Aspinall 1979; Putzier et al. 1985).

Crow et al (1995) compared the cognitive components of nursing assessment and medical diagnosis. They suggested that there are both similarities and fundamental differences between these two processes. Both assessment and diagnosis involve a directed search for information and normally result in predictive judgements. Two main differences emerged in relation to the purpose of the information search and the frequency with which assessments and diagnosis were reviewed. The purpose of the information search in medical diagnosis is to provide a causal explanation for the signs and symptoms that the patient presents so that a treatment regime can be initiated. In nursing assessment, the information search is carried out to provide an accurate picture of the patient's condition at that moment in time and to allow the nurse predict for the future.

Carroll and Johnson (1990) distilled the work of several theorists and proposed a *descriptive model of decision-making* with seven stages:

Recognition – decision-making begins with the recognition that a problem exists and a decision has to be made

Formulation – if a situation is recognised as one where a decision has to be made the next stage is to explore and classify the decision and formulate initial impressions

Alternative generation – the process of generating a number of alternatives of the problem

Information search – collecting information about the alternatives under consideration

Evaluation/choice – allows the decision maker to rate the importance of various attributes and to choose from the alternatives for action

Action – implementation of decision

Feedback – from action which allows decision behaviour to be modified.

Bryans and McIntosh (1996) critiqued the work of Carroll and Johnson and suggested that the breadth of the conceptual base provided by this framework could facilitate the examination of the whole process of assessment in district nursing practice. The first two stages, problem recognition and formulation, were described as predecisional activity. Bryans and McIntosh identified that this important phase of the decision-making process is excluded from other descriptive models including the nursing process and the hypothetico-deductive approach. As DNs receive some information (however limited) at the time of referral from GPs and following hospital discharge, and may also access information about the patient's medical history, the predecisional activities are likely to influence the approach of the DN to the first visit. Bryans and McIntosh (1996) also suggested that the personal view of the DN of her role and the anticipated situation or assessment task the DN was likely to face, influenced this stage of the decision-making process.

Additionally, the role of feedback in modifying decision behaviour was excluded from other decision-making models. If assessment in nursing is concerned with the situation of the patient at a particular moment in time, then feedback on actions arising from decision-making seems essential and particularly relevant to district nursing practice where the patient's preferences and home situation are also crucial to the planning of care. Carroll

and Johnson's (1990) framework was also used in this current study to explore the breadth and scope of decision-making in DN assessment practice (Chapter 6)

Prescriptive models of decision-making

Decision analysis is an example of a prescriptive approach to decision-making and is the formal technique of decision theory. This is a quantitative approach to decision-making which can be used under certain (probabilistic) and value-laden conditions. A model of the problem is constructed highlighting the available options and the potential consequences of following each. In this process the decision-maker (preferably the patient) estimates the probability that specific interventions will lead to specific outcomes and assigns values to each possible outcome (Corcoran 1986).

This approach is an example of system-aided judgement and a more analytical approach (Dowie 1996). This technique may be relevant to certain aspects of nursing practice. For example, patients may be offered steroids or chemotherapy as palliative treatment for metastatic disease where the treatment will not alter the underlying pathology. Additional treatment may result in distressing side effects thus diminishing further quality of life for the patient and family. Decision analysis could potentially allow the patient to work with health care professionals in reaching an 'informed decision'. The principles of decision analysis could also be utilised in relation to appropriate treatment choices and symptom control (Corcoran 1986; Kennedy 1999).

As many of the situations encountered by DNs may be complex, multi-factorial and have a range of possible solutions, decision analysis might have limited application to many of the problems encountered by DNs at the assessment visit (Bryans and McIntosh 1996). However, as the purpose of conceptual models is to offer a range of tools to support and develop practice, it is important that nurses analyse and explore their utility and potential to enhance the decision-making process. A considerable advantage of decision analysis is the amount of patient involvement required in the decision-making process. As the patient has to assign their values to the predicted outcomes, the scope for ensuring individualised care could be enhanced. In the community setting where patient compliance with prescribed treatments may be difficult to achieve and monitor, patient centred decision-making seems crucial.

A number of studies in medicine and nursing, have demonstrated that decision-making can be improved by increasing the amount of analytical thought. For example, in an American study, Aspinall explored the use of decision trees to improve accuracy in nursing diagnosis and found there was a significant difference between the groups using the decision trees as opposed to those who did not (Aspinall 1979).

This section of the review identified two main types of decision models – descriptive and prescriptive models - which adhere to the rationalist perspective of decision-making by virtue of their systematic approach to the process. It is clear that analytical judgement adheres to the ethos of evidence based practice and yet nurses appear reluctant to embrace these principles to make their decision-making explicit to others, especially patients and families.

2.4.3 Intuitive judgement in nursing

Since the work of Benner (1984), intuitive judgement has been described as a process independent of linear reasoning processes based on various techniques (Rew and Barrow 1987). These include ‘pattern recognition’, or the ability to identify when a situation is different from an expected pattern, and being able to use past experiences to draw on salient issues in the situation encountered (Eraut 1994; Easen and Wilcockson 1996).

Rolfe (1998) proposes a theoretical model of professional judgement that integrates personal, experiential and scientific knowledge with reflection *in* and *on* action. This integration results in the nurse constructing a personal theory which Rolfe (1998) argues is context specific – referring only to this patient in specific practice situations. The significance of the context and recognition that personal theory cannot be universally applied, distinguishes it from scientific theory.

For example, when faced with the problem of whether to tell a patient he is dying, the nurse draws on a range of knowledge and in particular, personal knowledge built up through reflecting on action in similar situations. She knows that telling some patients may increase their anxieties. On the other hand she knows that many patients draw comfort from being told the truth. The nurse also knows that the patient has the right to know the truth, has personal knowledge of the patient and a good idea how the patient may respond. She decides to probe further to determine that the patient does want the information and

constructs a personal theory that the patient should/should not be told. The nurse gets immediate feedback from the patient about her actions that can be used as a personal learning experience for future similar situations.

Rolfe's theory can be challenged in two main respects. Firstly, the ability of the nurse to reflect on action in depth whilst in the midst of dealing with many of the situations encountered, is questionable. Secondly, there is no acknowledgement that the nurse's interpretation of the feedback from the patient may be inaccurate. This could result in the implementation of inappropriate strategies for future practice.

The confusion between intuition as a mode of cognition and intuition as a type of knowledge has been identified in Section 2.3.5. Intuition is characterised by "...a lack of conscious insight into either the knowledge used to make a choice, or the process by which that choice was made" (Lamond and Thompson 1999 Pg. 3).

Decision-making frequently involves the nurse in making decisions that have a direct effect on the patient and family who have their own beliefs and values. Therefore over-reliance on intuitive knowledge and modes of cognition obscure the basis of decision-making from patients and others members of the profession. It should be acknowledged that to date the *quality* of intuitive decision-making is relatively unexplored. The inherent difficulties in exploring intuition, particularly where the decision may not have had a good outcome, are clear.

2.4.4 Discussion and implications for district nursing practice

The debate surrounding the nature of clinical decision-making is complex. In district nursing practice there are certain decisions that are likely to be made at the first assessment visit. These include prioritising short and long-term needs, and in particular, determining those needs which must be met at the first visit and those which can be left for the future. The DN has to determine visiting patterns at the first visit and decide if the patient requires to be visited again, and if so, how frequently. The patient may also need to be referred to other agencies for assistance.

When considering decision-making in the community the situation of the patient at that particular time and their social circumstances needs to be acknowledged. At the initial

encounter with the patient and family, the DN may be faced with a number of problems which will vary in complexity. Some problems will be easily recognised and dealt with, while others may require longer term investigation and planning (Bryans and McIntosh 2000). The information required by the DN upon which to base her decision-making may be very personal to the patient and therefore the relationship formed between the DN and patient, and the manner in which the DN tries to gain that information, is paramount.

Luker and Kenrick (1992), in an exploration of the sources of influence on the clinical decisions of community nurses, found that experiential knowledge and situational factors were frequently cited as the rationale for decisions. The authors suggested this was because the DNs might reclassify scientific knowledge as experiential knowledge.

However, nurses can become aware of the processes underpinning their decision-making by utilising reflective processes. The utility of the principles of decision analysis in helping patients' decide about treatment options is worthy of further exploration although many of the decisions made by nurses appear to be more suited to the intuitive approach. The potential problems of a largely intuitive approach to decision-making in a health care system where the debate surrounding evidence-based practice is prominent, should be acknowledged.

In the community setting, the context in which the visit takes place, the patient's home and social circumstances are likely to impact on decision-making. The situations DNs often encounter are complex, with some of the information which might be useful in informing the assessment process being difficult to uncover. Decision-making in the community setting is therefore likely to be an individualised activity influenced by a number of determinants including what is acceptable to the patient and family, the social circumstances and the resources available in the area.

Some studies exploring decision-making in health care have been carried out as simulations. For example, the work of Bryans (1998) used two simulated cases; a patient with multiple sclerosis and a patient with venous ulceration to explore the practice-based knowledge of district nurses. This method allowed the direct comparison of the first assessment of the same patients. It revealed important information about knowledge in use and identified different approaches to the assessment of the same patient by the study participants. In particular, the study revealed that variations between participants assessing

the same case related to the prioritising of patient needs and the use of contextual reasoning. Two approaches to assessment by DNs were observed, patient-focused and nurse agenda-led. The patient-focused approach, where mutually agreed goals were established, resulted in patients being more willing to disclose information to the DN and responsive to her suggestions and advice. Where the assessment agenda was nurse-led, the patients' participation was inhibited and they were less likely to respond to suggestions and advice. Bryans (1998) also distinguished between needs assessment as being essentially evaluative and patient assessment as inherently social. The influence of the context on the assessment process was therefore noteworthy.

2.5 Summary and conclusions

Changes in health care policy continue to reinforce the role of primary health care and DNs will be expected to contribute on an ongoing basis to the development of health care services. Programmes of education for DNs have undergone profound change and DNs are now educated to at least degree level (UKCC 1994a; UKCC 1994b). The current drive towards practice based upon 'best evidence' reinforces the need for life long learning in order for the DN service to develop in keeping with the demands made on the service.

Whilst the role of the DN is changing in some respects, responsibility for the first assessment visit and for assessing the needs of patients and carers remains with the qualified DN. To date, there is limited evidence to support the need for a qualified DN to carry out this aspect of the role. In the current climate, where cost containment and the increasing use of a skill mix are important, it is unlikely that this aspect of the DN role will remain unchallenged. Therefore, it seems essential to add to the body of knowledge about the contribution of the DN to needs assessment in the community setting.

To date, the tendency in nursing has been to construct typologies which differentiate and distinguish between different types of knowledge. This classification is normally based on the sources of such knowledge and the relevance of this type of approach to the realities of nursing practice may be limited. Additionally, it could be argued that the 'importance' attributed to one source of knowledge, for example empirical knowledge, rather than personal knowledge has limited the exploration of nursing knowledge in use.

The main focus of the literature is on the debate in relation to the nature of the knowledge required to support nursing practice. Whilst there is increasing interest in the exploration of all types of knowledge in nursing, the review identified the particular interest in the exploration of the knowledge embedded in the practice of experienced nurses. The processes of thinking and doing have been considered to be separate entities in nursing practice. It is important to emphasise the inherent difficulties in identifying the knowledge nurses use in practice. Separating empirical or theoretical knowledge as distinct from personal and moral knowledge, which may be virtually invisible, is particularly difficult and seems to demand research approaches where the connections between thinking and doing can be explored.

Studies relating to clinical judgement and decision-making in nursing are at a relatively early stage of development, as opposed to fields such as psychology and medicine. The debate surrounding clinical judgement and decision-making reflects the art/science dichotomy outlined in the nursing knowledge literature. Most of the work relevant to nursing focuses on information processing theory such as the nursing process and the hypothetico-deductive approach. There is, however, intense interest in nursing practice in relation to intuition as either a form of knowledge or as a mode of cognition.

A significant debate surrounding the decision-making process is the mode of cognition used by nurses. One school of thought suggests that the mode of cognition utilised is dependent upon the nature of the decision-making task to be undertaken. Counter to this, is the view that the mode of cognition relates to the expertise of the nurse rather than the decision task. The reality may lie somewhere between these two positions as the expertise of the practitioner may influence how they are able to utilise the appropriate mode of cognition for the decision-making task.

The literature review has revealed that further exploration of the nature of the knowledge base underpinning practice, whilst difficult, is essential. Similarly, securing a better understanding of the processes used by health care professionals to make judgements and decisions about patient care is essential to the development of a knowledge based NHS and practice based on best evidence.

In recognition that assessment is a fundamental aspect of the district nursing role, this study aimed to explore the nature of the knowledge in use in the assessment process and identify the relationship of this knowledge to the decision-making process. Adding to the body of knowledge about the assessment of needs by DNs due to the changes in policy, education and practice identified in Chapter 1 was considered to be important and timely. An assumption underpinning this study is that the exploration of knowledge in use and decision-making processes can be enhanced by combining the observation of practice with self-reports of the situation observed by the study participants (Meerabeau 1992). Exploration of knowledge in use seems to demand a systematic and interpretative research approach where the impact of the context can be explored - the aim of this study

CHAPTER THREE: RESEARCH DESIGN AND METHODS

3.0 Introduction

The aims of the study, the approach selected for the study and the methodological issues will be explained in this Chapter. At the early stages it was considered that the aim and objectives (Section 3.1) would best be met by qualitative approaches. Qualitative research, as a set of interpretative practices, utilises many approaches including phenomenology, grounded theory and ethnography. These research approaches all have potential to provide important insights and knowledge (Denzin and Lincoln 1994).

3.1 Study aim and objectives

The aim of this study was to uncover the knowledge held by DNs and to analyse how they use this knowledge in their decision-making and practice, in relation to first assessment visits.

Study objectives

- to identify and categorise the knowledge in use of DNs undertaking first assessment visits (*this objective was subsequently revised – see Chapter 5, Section 5.0)
- to identify and classify the basis of decision-making by DNs during first assessment visits
- to make explicit, the relationship between the knowledge base of the DN and her decision-making practice.

3.2 Qualitative and quantitative research

Within nursing literature it would appear that an important issue facing nurse researchers is reaching agreement on appropriate philosophical and methodological stances in nursing research (Whitehead 1998; Marks-Maran 1999). This was described by Guba and Lincoln (1994) as the "paradigm wars" representing the debate about the merits of quantitative (positivist) and qualitative (naturalist) methods of enquiry.

Quantitative methods are based on the scientific method and modelled on the processes used in the natural sciences. They involve measurement, deductive reasoning, causality and hypothesis testing (Mackenzie 1994). Quantitative studies tend to have a clearly defined

focus, large sample sizes and data that can be tested by using a set of procedures and rules. The drive for nursing to contribute to the establishment of a sound body of nursing knowledge and the emphasis on a knowledge based NHS may be seen as an incentive for nurse researchers to adopt the positivist approach (National Health Service Management Executive 1994; Wilson-Barnett 1998).

Mackenzie (1994) suggests that the dichotomy between quantitative and qualitative approaches is a result of the epistemological debate about scientific knowledge. Positivism encompasses the philosophy of the natural sciences which are accepted as the benchmark of all scientific research and for some, positivism has become the underpinning philosophy for all research.

This poses a major problem for supporters of naturalism who argue that it is difficult to standardise interpretation of phenomena as individuals respond according to their interpretation and understanding of specific situations. They propose, therefore, that the world should be studied in its "natural state" (Hammersley and Atkinson 1983; Leininger 1985; Mackenzie 1994; Hammersley and Atkinson 1995). This debate is relevant in the context of much nursing research (Pollock 1991). Hammersley & Atkinson (1995) suggest, however, that despite their differences, positivism and naturalism share much in common. They argue that both seek to understand social phenomena independently of the researcher and for the most part regard the practical and political commitments on the part of the researcher as a source of distortion that may affect the objectivity of findings.

In qualitative (naturalist) methods, the social researcher studies phenomena within the natural setting in order to understand human behaviour. This approach, it has been suggested, allows the researcher to interpret people's worlds and understand behaviours, opinions and interactions using real examples (Hammersley and Atkinson 1995).

3.3 Qualitative approaches

The main qualitative approaches are ethnography, grounded theory and phenomenology. Before considering each of these approaches it is important to note developments in social research methods in the last decade in order to set the approach selected for this study in context.

Acceptance of qualitative approaches has increased since the 1990's; at the same time, naturalism has been scrutinised by qualitative researchers themselves (Hammersley and Atkinson 1995). Atkinson (1995) states, for example, that no single set of theoretical or methodological presuppositions underpins qualitative research, nor is there an uncontested collection of research approaches. He argues that classifying and clarifying the array of qualitative approaches such as ethnography and grounded theory in a rigid manner is essentially wrong and can ultimately distort the true picture. It is essential for students and qualitative researchers to be acquainted with different approaches, methods, perspectives and theories. However, Omery (1988) suggests there should be no hard and fast distinction between qualitative methods of enquiry. Atkinson (1995) and Omery (1983) acknowledge the importance of such theories and perspectives but argue that it is hard to see them as collections of research methods and still less as elements of a paradigm or widely accepted view.

In contrast, Leininger (1992) highlights the need to maintain the boundaries within the qualitative paradigm. She notes:

"Researchers sometimes model qualitative methods to suit their own desires and theoretical notions. The method used may not resemble the original one. The originating author's intent, philosophy, and methodologies may not be upheld" (Leininger 1992 Pg. 408).

Research textbooks contain descriptions of a wide array of qualitative approaches. Tesch (1990) offers the painter's palette as a metaphor to illustrate the diversity of recorded qualitative approaches. She suggests that the basic colours that can be mixed to produce an unending variety of shades can represent qualitative methods and traditions. This allows the researcher to create their own unique shade whilst adhering to the qualitative tradition. Tesch (1990) states:

"Just because some investigator has given her particular 'shade' a name and has written about it doesn't mean that it must be used in exactly that way for evermore - always keeping each of its tenets intact. To be sure, some types of research, and some labels, catch on more strongly, or have a longer tradition than others...basically there is but one requirement from research; that you can persuade others that you have indeed made a discovery worthy of paying attention to" (Tesch 1990 Pg. 71).

Grounded theory, phenomenology and ethnography all have potential to provide important insights and knowledge. These approaches share certain features including the centrality of

the subjective experience and the multiple realities that can exist within any phenomenon. Each has different traditions and philosophies and an overview of each approach follows.

Grounded theory was developed during an important period of growth in social research in the 1960's and the 1970's and is often cited in research literature as the dominant framework underpinning many qualitative studies. Atkinson (1995) states that grounded theory is not a philosophical position or a theory in itself. Grounded theory has its roots in certain sociological theories and the theoretical framework is derived from symbolic interactionism. Symbolic interactionism focuses on the symbolic meanings that people attribute to events and transactions in their lives, and on the ways people interact within their social roles (Glaser and Strauss 1967; Holloway and Wheeler 1996).

Grounded theory begins with an area of study and what is relevant to that area is allowed to emerge; therefore, the research does not begin with a hypothesis to test. The essence of grounded theory is that the concepts and theory that emerge are inductively derived from the phenomenon investigated. The theory is therefore grounded in the data. The research process involves formulation, testing and redevelopment of propositions until a theory develops. Central to the grounded theory approach are the principles of data saturation and theoretical sampling (Strauss and Corbin 1990) with data gathering and analysis occurring concurrently.

Phenomenology is variously interpreted as a philosophy and a research approach which focuses on the meaning of the "lived experience" for the individual with the purpose of promoting human understanding (Cohen 1987; Morse and Field 1996). The researcher asks the question "what is it like to have a certain experience?" It is a requisite of phenomenology that the researcher comes to the study with few preconceived notions, expectations or frameworks (Omery 1983) although the extent to which this is possible is arguable. The goal in the phenomenological method is to provide an accurate description of the phenomena being studied unlike grounded theory where the goal is to develop theory (Morse and Field 1996).

Ethnography represents the third major branch of qualitative research. Ethnography has a long history with its roots in anthropology and has been described as the most basic form of social research (Hammersley & Atkinson 1995). The overall aim of ethnography is to make one culture understandable to another and may be considered to be a generalised

approach to developing concepts and to understanding human behaviours from the insider's point of view (Morse & Field 1996).

Ethnography is informed by the concept of culture and a critical assumption is that any human group, which is together for a period of time, will develop a culture (Baillie 1995). An ethnographic approach may be used to examine, for example, the health beliefs of ethnic groups, or the beliefs and practices of delineated communities such as operating rooms. It may also be used when examining groups of individuals experiencing a common illness or group behavioural norms including clinical decision-making (Stein 1991; Morse and Field 1996). In relation to district nursing, this approach can deepen understanding of shared meanings, customs and rituals in district nursing practice (Ong 1991; Worth 1999). For example, visiting patterns to patients appear to follow certain trends and DNs often make decisions about the appropriateness of the referral: - does the patient require care from the DN service or is social care required?

Fetterman (1989) describes ethnography as the art and science of describing a group or culture (Fetterman 1989). Leininger (1985) specifies how this might be achieved by defining ethnography as a systematic process which includes observing, detailing, describing, documenting and analysing what is going on in a specific situation in order to explain the culture of specific groups of people. Hammersley and Atkinson (1995) interpret ethnography in a more flexible way by viewing it as a set of methods involving the researcher participating in people's lives for a period of time and collecting data to explain the topic under study.

Ethnographic studies are conducted in the natural setting where the phenomenon under investigation actually occurs and normally involve an eclectic research style resulting in an extensive account of the phenomena being studied. Ethnographic studies normally employ multiple methods of data collection including participant observation, interviews and field-notes.

Reflexivity is an important concept in ethnography. Social researchers are part of the world they study and practising reflexivity involves being aware of the ways in which the researchers' experiences and assumptions affect both the research processes and the outcome. It also involves being able to demonstrate to the readers of the research how this happens (Williams 1995). Leininger (1985) states that in ethnography the researcher enters

the field with an outsider's (etic) view and aims to achieve an insider's (emic) view. Acceptance of and trust in the researcher by the respondents is essential in ethnographic studies. As the researcher in this study had an understanding of the assessment process, a balance had to be achieved between distancing the personal perceptions of the researcher about how assessment should be carried out with trying to capture the essence of the process as carried out by the participants.

Morse and Field (1996) discuss the merits of a more delineated ethnography which has evolved in health sciences – focused ethnography. The ethnography is still context bound but the specific topic under investigation is selected before data collection commences. Participants share behavioural norms and participant observation is limited to particular events or times with interviews focused around the topic and surrounding event. This description reflects the approach adopted for this study which focused on the first assessment visit.

3.4 Selection of a qualitative approach

It has been argued by some that the primary purpose of qualitative research is to develop rich descriptions thus adding to knowledge. Each of the approaches outlined above adopts a different stance in seeking answers to research questions. Selection of the "best" or most appropriate approach depends on what the researcher wants to know, the expected outcomes, the constraints on the setting, the subjects and the resources (Morse and Field 1996).

As this study was not predominantly concerned with focusing on the meaning of the experience for an individual, phenomenology did not seem an appropriate approach for meeting the aims of the study. Its emphasis on in-depth reflective descriptions to elicit the "essence of experiences" could be relevant to the study but was thought to represent too narrow a focus (Denzin & Lincoln 1994). It was not the sole aim of the study to explore the 'experience' of assessment for either the patient or the nurse. Additionally, the researcher's background in district nursing practice and education meant that it was not possible to come to the study with no preconceived ideas or expectations.

Some of the principles of grounded theory, such as constant comparative analysis, were relevant and facilitated exploration of data in this research. However, it was not considered

appropriate to adopt all aspects of this approach as the researcher had experience and knowledge of the area under study, first assessment visits, and had identified that certain relevant theoretical frameworks already existed at the start of the study in relation to knowledge and decision making.

Ethnography was therefore the approach selected. The focus on perspectives and activities in the natural setting, in the context of this study, the patient's home, and the substantial reliance on participant observation in such research provided the starting point for this study. It was considered essential to incorporate one of the main methods of ethnography, participant observation, in the study. McIntosh (1996) discusses the concept of the DN as 'guest' in the patient's home. She suggests that knowing how to act in a patient's home is much more than the 'common sense' it is often attributed to and that the key to uncovering the knowledge base in practice may lie in the combination of observation and explication of practice by the practitioner (Meerabeau 1992; McIntosh 1996). Both observation and interview were selected as the key methods in this study.

Additionally, as ethnography seeks to describe the social and cultural world of a particular group (Emerson 1983; Morse and Field 1996) it was felt that this study might generate information about district nursing practice as a sub-culture within the larger social context of community nursing.

3.5 Research approach and methods

The ethnographic approach utilised in this research was primarily inductive, employing multiple methods and represented the more focused ethnography outlined by Morse & Field (1996). The design moved beyond description towards theory development using a humanistic interpretative approach and exploratory techniques (Atkinson and Hammersley 1994; Hammersley and Atkinson 1995) to illuminate hitherto covert patterns of behaviour and rationales for decision-making. This interpretative approach searched for meaning within the cultural norms, culturally patterned behaviour and cultural context of district nursing, using insights of the district nurse themselves.

Following exploratory work (Section 3.8) the data collection and analysis were conducted in two phases:

Phase 1

February 1997 – February 1998	Observation of first assessment visits and follow up interviews
February 1998 – August 1998	Analysis of 11 data sets

Phase 2

September 1998 – February 1999	Second interview with participants
March 1999 – September 1999	Data analysis of all interview and field note data
January 2000	Focus group with participants to discuss findings

The following sections describe the research methods adopted for this study and an overview of the whole research process is contained in Figure 1.

3.6 Selection and recruitment

Qualitative research is sometimes criticised for the way in which selection or sampling of participants is undertaken, as the processes adopted are often considered to be less rigorous than those in quantitative enquiry (Dowell et al. 1995). Descriptions of qualitative sampling methods in current literature are confusing and there exists considerable overlap between descriptions of types of sampling (Coyne 1997). The main purpose of sampling is to select information-rich cases, which allow the researcher access to the phenomena under exploration. Patton (1980) proposes that all sampling in qualitative research can be classified as purposeful as it seeks to provide insight to the phenomena under study. Within this broad definition he describes 15 strategies for purposefully selecting information-rich cases one of which is convenience sampling, the strategy adopted here.

Eleven DNs participated in the study, recruited from one area of a Community Health Care NHS Trust. A total of 25 qualified DNs in the area were potential participants. The Nurse Manager invited the researcher to speak to the DNs following a staff meeting, 20 of whom were present. An outline of the study was presented and a lively discussion followed where the researcher and DNs discussed some of the practicalities that would facilitate the data collection phases of the study. The response from the DNs and their manager to the study was positive and supportive and the DNs present at the meeting agreed, in principle, to take part.

In the initial stages, the researcher tried to undertake data collection on a one day a week basis but it proved impossible to match the availability of first assessment visits with the researcher's available time. The researcher negotiated weekly blocks of study leave with her employer. It was also felt that a more general presence over a week, as opposed to the researcher turning up only for relevant visits, would lessen the potential impact of the researcher on the DNs' actions. Impressions from practice would support this assumption as the DNs appeared relaxed and open with the researcher. It was considered that the presence of the researcher in the practice areas for weekly blocks would enhance the opportunities to observe first visits. However, it is important to emphasise that despite these measures, observation of numerous visits was not an option. For example, one week spent in the field in December 1998 resulted in one first assessment visit on the last afternoon.

A total of six weeks was spent in the field and during this time, 12 first assessment visits were observed (one DN was accompanied on 2 first visits). Prior to going out to the field on each occasion, the researcher wrote to every DN in the area telling them at which health centre the researcher could be contacted. The DNs were invited to contact the researcher if new visits became available and they wished to participate in the study. DN 3 and DN 11 contacted the researcher when she was based at a different health centre to that at which they worked. The other visits were drawn from the DNs who were located at the health centre in which the researcher was based for that particular week. Both the large volume of data generated and the complexity and amount of time involved in collecting data by observing real visits precluded large sample numbers (see Section 3.9 for further discussion).

The demographic details of the study participants are described in Section 3.7 and in Table 1 (Pg.77).

3.7 The study participants

The 11 qualified DNs who participated in the study completed a form (Appendix 2) giving an overview of their biographical and professional details. These are shown in Table 1.

It can be seen that there was considerable variation in length of experience as a DN; from 3 months to 33 years. There was also variation in the level of DN qualifications, with only one DN (DN 7) holding a graduate level qualification in district nursing. DN 8, completed a degree at pre-registration level with the achievement of the DN Certificate as an integral part of this programme. A further 3 DNs were graduates and had completed degree level studies as 'top up' programmes.

This profile resonates with the changes in DN education from Certificate, to Diploma and Degree levels of preparation (UKCC 1994a; McIntosh 1996).

Table 1 DISTRICT NURSE BIOGRAPHICAL / PROFESSIONAL DATA

	GRADE	AGE YEARS	YEARS AS DN*	DN QUALIFICATION			OTHER ACADEMIC AWARDS	OTHER EDUCATION TRAINING	VISIT/S OBSERVED
				Certificate	Diploma	Degree			
DN 1	G	30-39	5		*		BSc (Hons) Health Studies	Nurse Prescribing	Hygiene Assessment
DN 2	G	40-49	7		*				Wound Dressing
DN 3	G	30-39	5		*		BSc (Advanced Nursing)	Short Course in Palliative Care	Hygiene Assessment
DN 4	G	50-59	25	*				Range of Community Nursing up-dates	Wound Dressing BP Monitoring
DN 5	G	50-59	33	*				Nurse Prescribing	Wound Dressing
DN 6	H*	60+	21	*				Nurse Prescribing	Skin Rash
DN 7	G	30-39	3 months			*		Going to commence MSc (Nursing)	Wound Dressing
DN 8	G	30-39	11	*			BSc (Social Science)	Leg Ulcer Management Course	Doppler Assessment
DN 9	G	30-39	1		*		BA (Community Health)	Nurse Prescribing	Contenance Assessment
DN 10	G	40-49	10		*			Wound Management Module	Wound Dressing
DN 11	G	30-39	10		*			Leadership Course	Wound Dressing
	*Community Practice Teacher		*Time of First Interview						

3.8 Exploratory phase

An important issue for researchers embarking upon research within the interpretative tradition is to decide whether the adoption of a clearly defined pilot study is in keeping with the stated aims of the study. It was considered important in the current study to test and refine the data collection methods but due to the difficulties in accessing first visits and the inductive nature of the study, it was, therefore, determined that a pilot study was unlikely to enhance achievement of the study aims.

Exploratory work was undertaken in relation to both observational and interviewing techniques. The processes involved in designing the framework for organising field notes are described in Section 3.9. At this time the researcher had very close practice links with a group of DNs and this provided opportunities to work with them and refine this framework. Similarly, two DN colleagues agreed to be interviewed to allow the researcher to focus the interview structure, assess the quality of the data and refine personal interviewing techniques.

3.9 Participant Observation

Participant observation is one of the main methods of data collection in ethnographic research and combined with in-depth interviewing may illuminate hitherto covert patterns of behaviour and decision-making. Participant observation has its origins in anthropology and sociology and developed from Malinowski's anthropological study of culture on Pacific Islands (Malinowski 1922). In nursing, ethnography has been used to explore specific groups of patients; for example, following cardiac surgery (Preston 1993); particular groups of nurses or students (Mackenzie 1992; Spouse 1997) and wards or units (McCormack 1992).

In nursing, possible sites for nurse observers are endless and vary on a continuum from open (public) to closed (private) settings. Gaining access to closed settings can be difficult as discussed below. The role undertaken by the researcher may range from, complete observer; the participant as observer; the observer as participant to the complete participant (Gold 1958). Whilst the roles of complete participant or complete observer are relatively

clear, the distinctions between participant as observer or observer as participant are less clear. In this study, the latter role was adopted.

Hammersley and Atkinson (1995) advise that the role adopted by the researcher can not only be influenced by the nature of both the setting to be studied and the research, but can also change throughout the fieldwork. The aim of this study was to explore the knowledge base and decision-making of the DNs so the role of complete participant was excluded immediately. As the DN was accompanied to the patient's home, the role of complete observer (a covert activity) was not appropriate. Given that the researcher was a qualified DN, the role of participant as observer may have been appropriate. This role however, tends to suggest an equal partnership. As the researcher was known to many of the district nurses through contacts in education and practice, the role of observer as participant seemed to be the most appropriate one to adopt. In this role the observer is only marginally involved in the situation (Holloway & Wheeler 1996), not working as a district nursing colleague but willing to participate in the care of patients where appropriate or essential. This position was adopted to minimise the presence of the researcher and her impact on the situation. District nurses are used to working alone and the relationship they build with patients in their own homes is vital.

Hammersley and Atkinson (1995) highlight the difficulties of gaining access to the field. Contact was made in the early stages of the study with appropriate community nurse managers and verbal support was given for the study to be carried out in a Community Health Care NHS Trust. Ethical approval was granted (a process which took 6 months and is described in Section 3.11), and nurse managers were contacted to arrange for the start of data collection. At this point, the gatekeepers - the locality managers - refused access. Without permission from the gatekeepers at the top of the management structure there was no way of negotiating access with the people who would be most affected by the research activity - the district nurses and their patients.

Hammersley and Atkinson (1995) state that gatekeepers may view the ethnographic researcher as 'the expert' or 'the critic'. Both of these models may influence the gatekeepers in relation to the potential outcomes of the research. Such fears of the researcher as an expert or critic may apply to the locality managers approached in relation to this study. The researcher was a qualified and experienced DN and Teacher so the locality managers may have believed the researcher would evaluate and possibly criticise the practice of the DNs

in relation to first assessment. Fortunately, access was granted to another area which was covered by the same Research Ethics Committee (Appendix 3).

First assessment visits in district nursing can be unpredictable. The DNs rarely had more than one day's notice of new visits and often less. Additionally, issues such as patients not being discharged home as expected and staff illness presented interesting challenges to the part time researcher. In the exploratory stages of data collection it was almost impossible to match the researcher's availability with that of suitable first visits. There was no sense that the DNs were avoiding contacting the researcher because they were unwilling to take part in the study. However, contact with DNs on a fairly ad hoc basis was not conducive to them remembering, in the midst of a heavy and demanding workload, about the study. These difficulties were overcome to some extent by using one-week blocks for fieldwork.

The role adopted by the researcher during periods of observation must be clearly defined from the outset. The researcher knew most of the DNs who participated in the study with some being former students. Being known as a DN could have led to difficulty in asking apparently naïve questions. A balance had to be achieved between establishing trust and rapport whilst retaining enough distance for the purpose of data collection.

The researcher wore a uniform when visiting with the DN. It could be argued that this might have misled patients by hiding the identity of the researcher. However, as the interaction between DN and patient involved the patient giving the DN personal information, and often also involved the completion of personal tasks, it was decided that the patient might feel more comfortable if the researcher appeared as a fellow professional.

Where possible, the DN telephoned the patient prior to the visit and asked permission for the researcher to be with her at the visit. If this was not possible, the DN sought permission at the door. The researcher informed the patient of her status and intentions and clarified the purpose of the research for the patient. Impressions from visiting with the DNs were that patients were relaxed and did not feel threatened in any way by the presence of the researcher. Written permission from patients was gained after the DN had completed all her activities. In all the cases observed, the patients (and one carer) gave written consent freely, often not waiting for an explanation from the researcher.

In relation to the DNs, some seemed anxious that they were going to be watched by a colleague. Experience suggests that the journey to the patient's home in the car of the DN and the actual 'getting on with the visit' eliminated these anxieties. Prior to the visit the researcher told the DNs that she would not participate in the visit other than carrying out some very simple tasks unless the situation required two nurses. During the visits the researcher performed simple tasks such as opening dressing packs, fetching and/or disposing of water and supporting a patient's limb during bandaging. Participation in these simple activities helped to minimise the presence of the researcher as observer. During the follow up interview the DNs appeared relaxed and the data collected suggested that they felt comfortable with the researcher.

Going out into the field as a district nurse to observe assessment practice caused some personal anxieties as to what should be observed. There were concerns that important data would be "sieved out" because it was so familiar. Spradley (1980) states that observers progress in three steps and use descriptive, focused and finally selective observation. In descriptive observation, every detail is recorded and is guided by the general questions the researcher has in mind. Focused observation results in certain areas or events becoming more obvious with the researcher focusing on these to a greater extent. Eventually the observation will become highly selective (Spradley 1980). In this study, the framework for field notes developed by the researcher, and described below, facilitated selective observation.

Exploratory work in the proposal writing stage of the study included working with district nurses and observing their practice. Initially, the framework for observation outlined by LeCompte & Preissle (1993) was adopted for organising field notes. This framework covers who, what, where, when and why questions.

The researcher took notes in the car while travelling to the patient's home with the DN, throughout the visit, and in the car afterwards. There was no structure to the notes at this stage in both the exploratory and main phases of this study and as much detail as possible was written, including significant phrases and actions by the DN. As soon as possible, predominantly the same day, the field notes were written up. Using the questions outlined by LeCompte & Preissle (1993) as a framework for the field notes did not seem to reflect the essence of the visit as experienced by the researcher. The questions relating to, 'who' was there, 'what' was happening and 'where' the interaction was taking place resulted in

very descriptive data. The 'when do' conversations and interactions take place and 'why do' people interact in this way yielded slightly more in-depth data. However, it was judged that recording the field notes in this way would not facilitate exploration of the decision-making or knowledge base of the DNs.

A framework was needed which would focus in on the elements of the observations that related to the aims of the study. Two main activities – information seeking and cue following – were clearly vital. These headings were incorporated into the framework for writing up the field notes. The nature of the written information at the actual visit remained as broad ranging as possible but in order to focus the data, field notes were subsequently recorded under the following 8 headings;

- Demographic details of DN
- Source of patient referral
- The DN's comments prior to entering the house
- The visit
- Information seeking by the DN
- Cue following by the DN
- The perceptions of the DN post-visit
- The researcher's observation notes

Demographic details of the DN

In the car or clinic the researcher asked the DN about her caseload and the nature of the team in which she worked. Often the DN would talk about where and when they did their district-nursing course and about any courses or projects they were currently involved in. Further demographic details were collected at interview but general conversation helped to put the DN at ease. The majority of the DNs related their expectations of the visit at this time.

The referral

Information about the referral itself and any other accompanying information were recorded. For example, the referral was normally framed as a task – ‘wound dressing’ or ‘assess for bath’. If the DN had other information about the patient from medical notes, this was also recorded.

DN comments prior to entering the house

The DNs volunteered what they were expecting at the visit, which offered valuable insights into what they were thinking as they approached the assessment. If they did not volunteer this information they were gently probed to try to determine what was in their minds at this time.

The visit

The researcher's impressions of how we were greeted and how the DN introduced herself to the patient and family were noted as were the researcher's first impressions of the environment.

Information seeking

This section generated the largest volume of notes. The questions asked by the DN and her actions were noted in depth and included such information as "the DN asked ... while doing...".

Cue following

It was clear from the very early stages of this work that DNs responded to a variety of cues that were verbal, non-verbal, sensory and environmental and these were recorded. Cue following and information seeking were inter-related activities and some degree of overlap resulted in the field notes. However, it was considered important to retain the distinctions in the writing up process in order to assist the processes of information retrieval and data analysis.

DN perceptions post visit

Normally the DN offered, without probing, what they thought about the visit and gave some information about what they felt might happen in the future together with their perceptions of what was going on in the home.

Researcher's perceptions

Perceptions of the visit including how the patient responded to the DN and the DNs approach were recorded, as were overall feelings about the visit.

Notes

Issues relating to the mechanics of the visit; for example, obtaining consent from the patient were recorded under this heading together with the DNs' feelings about being accompanied.

Each observation resulted in a significant volume of data. It was judged that the categories outlined above provided a meaningful framework for dealing with the information which the observation visits provided. The relationship of this data to the interview data will become clear in the section dealing with analysis that follows (Section 3.13).

There are many challenges facing nurse researchers who adopt observation as a method of data collection. In this study, observing the interaction between the DN and her patient added an important dimension to data analysis which could not have been captured from interview alone. For example, the researcher was able to observe the ways in which the

DNs 'made the visit work'. DN 3 described in some detail how she had tried to make the patient (George) the focus of the visit (Chapter 6). Her detailed description at interview was enhanced by the observations of the researcher and supported the DN's perception of her approach. As the patient was the focus of the observed visit and the follow up interview, the data were 'brought to life' by the opportunity to observe real examples.

The position of the nurse researcher as observer provided a unique opportunity to explore aspects of nursing practice that would otherwise have been difficult to access. The dual role does, however, raise a number of challenges in terms of the method and the ethical issues surrounding participant observation. As a DN/researcher-observer there were some particular challenges in trying to ensure that a balanced interpretation was made of the visit. The framework already described was important in ensuring the credibility of the observations and subsequent field notes. It guided the researcher towards the activities of information seeking and cue following that were important to the aims of the study. Gaining informed consent (discussed in Section 3.11.1) was particularly important given that the patient, DN and researcher were meeting for the first time.

Throughout, the new perspectives of assessment that emerged through focused and selective observation surprised the researcher. For example, I had not fully considered the substantial reliance displayed by the study participants on interpersonal skills as a means of establishing trust and rapport with the patient (Chapter 4, Section 4.2). Also, although it was possible to identify examples from my own practice where anticipated future health needs had been a rationale for further visits, I had not considered the possible sources of knowledge underpinning such a decision (Chapter 4, Section 4.4).

Attempting to capture the context of care, the patient's home environment, and the practicalities surrounding observing first assessment visits in this study as outlined above, proved challenging.

3.10 Interviews

The interpretative approach recognises that meanings emerge through interaction and that understanding of these meanings can only occur in context. Qualitative research seeks to understand how and why things happen in a complex world and knowledge is viewed as situational and conditional (Rubin and Rubin 1995).

The qualitative interview has been described thus:

“...an interview whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena. Technically the qualitative research-interview is “semi-structured,” it is neither a free conversation nor a highly structured questionnaire. It is carried through following an interview guide, which rather than containing exact questions focuses on certain themes. The interview is taped and transcribed word for word. The typed out version together with the tape constitute the material for the subsequent interpretation of meaning” (Kvale 1983 Pg. 174).

The qualitative interview generally requires some structure and the researcher should focus the interaction without constraining the reflexivity of the interview. Patton (1980) identifies three approaches to open-ended interviews. The informal conversational interview is almost entirely participant led and often occurs in participant observation. The second approach involves the compilation of a general interview guide which outlines the issues to be addressed with each participant. The third and most structured approach, the standardised open-ended interview, consists of a set of predetermined questions and can be used to minimise variation and bias. Within each of these approaches it is essential that interviewees can respond in their own way.

The three approaches outlined above were utilised within the context of this ethnographic study which focused on first assessment visits. During participant observation the conversation was almost entirely led by the DNs although, as they knew the researcher was exploring first assessment visits, they tended to talk about this area of their work (this conversation was not recorded).

Originally, it was intended to interview each DN once following observation of the visit. As data were transcribed verbatim and preliminary analysis commenced it was decided, in agreement with the study supervisors, that rather than increase the number of participants in the study, the DNs should be interviewed a second time. The rationale for this decision was in part due to the difficulties experienced in accessing first visits (Section 3.9). Secondly, phase 1 analysis revealed the rich and complex data that had been collected from the 11 interviews. It was considered that collecting more in-depth data from the 11 participants was in keeping with the ethnographic approach which seeks to achieve thick description of the phenomena under study.

The first interview, which took place as soon as possible after the visit, was designed to explore some general areas in relation to assessment and particular issues which had arisen from the observation of the visit. A general interview guide was constructed to guide the first interview to ensure the participants were asked to recall the visit and explain what they had done and why (Appendix 4). Following analysis of the phase 1 data from the main study, the questions for the second open-ended interview (Phase 2) were designed to facilitate further exploration and clarification of important issues that had arisen (Appendix 5). This approach was designed to allow insight into complex issues by focusing the interviews but without constraining the participants' responses. The two interviews were conducted at the workplace of the DN and audio recorded. The researcher thought the DNs were relaxed and open throughout both interviews. However, the fact that the second interview was not linked to observation of a visit and could be prearranged, reduced the practical difficulties experienced during data collection in phase 1.

During the first phase, with one exception, all the DNs were interviewed immediately following the visit in their own workplace. One visit was completed late in the afternoon and that DN indicated she would rather be interviewed the following day. The second interview was conducted approximately one year after the observation of the visit and first interview. At the time of the second interview, three DNs were unavailable due to pregnancy, long term illness and retirement. The DN who had retired since the first interview had taken place was invited to continue her participation in the study, but declined.

Reflexivity is an essential component of the qualitative interview:

"The purpose of interviewing is to find out what is in and on someone else's mind. The purpose of open-ended interviewing is not to put things in someone else's mind (for example, the interviewer's preconceived categories for organising the world) but to access the perspective of the person being interviewed. We interview people to find out from them those things we cannot directly observe" (Patton 1980 Pg. 278).

Throughout data collection, the researcher endeavoured to maintain a balance where respondents could communicate freely without losing the focus of the interviews. The interviews sought to be probing and in-depth.

3.11 Ethical issues

Ethical issues have to be considered in all research, and the moral principles set out in professional codes provide a framework to assist the decision-making of the researcher (Holloway and Wheeler 1996). The principles contained within the Nuremberg Code (1964) have underpinned the development of medical and nursing guidelines for research involving human subjects (Royal College of Nursing Research Advisory Group 1993c; Royal College of Nursing of the United Kingdom 1998; Noble-Adams 1999a). In nursing ethics, the normative approach (what we should do) is primarily adopted. This approach is concerned with guiding professionals to "safeguard the interest and well-being of patient and clients" (UKCC 1992).

"Respect for persons" represents the guiding ethical principle in research involving human subjects (Eby 1995; Holloway and Wheeler 1996). "Respect for persons" is concerned with the rights of the research subject which must not be compromised by the researcher or the research process. These rights can be set within the four principles underpinning nursing and medical research - autonomy, non-maleficence, beneficence and justice. Rights to autonomy:- allowing participants to make free, independent choices without coercion. The rights to beneficence and non-maleficence: - acknowledging that the researcher is motivated to do good, and above all, avoid harm. Finally, research subjects have the right to expect justice: - that is, to be treated at all times with fairness (UKCC 1992; Beauchamp and Childress 1994; Eby 1995; Holloway and Wheeler 1996).

Ethical approval was sought from the Local Research Ethics Committee (LREC) (Appendix 3). In order to grant ethical approval, the Committee requires to be satisfied that subjects are adequately informed and have given informed consent to participate (Noble-Adams 1999b). Morse & Field (1996) state that informed consent can serve two functions; as written verification that the subject has agreed to participate and understands the implications of doing so, and to provide written explanation about the project to supplement verbal information given.

The Research Ethics Committee provided standard consent forms and stated that written information should be provided. It was felt that the standard consent form was not appropriate for use with the participants of the study (see Section 3.11.1).

The four key ethical principles outlined above underpinned the process of seeking approval for the study and are now considered in detail.

3.11.1 Autonomy

The process of achieving informed consent is central to autonomy and involves allowing participants to make free, independent choices based on information and without coercion. The flexible nature of qualitative enquiry and the focus on meanings and interpretations of individuals may result in the use of ideas generated through data collection. It was therefore essential to consider informed consent as an ongoing process of informed participation, which requires the researcher to renegotiate with participants throughout (Behi 1995).

The DNs were the key study participants. However, the patients whose homes were being visited had also to be regarded as participants and their rights respected. Accordingly, a consent form was constructed for the DNs (Appendix 6) and another for the patients (Appendix 7) and a separate information sheet was written for both (Appendices 8 & 9).

The focus of the study was the DN. Whilst the researcher did not ask the patient questions directly for the purpose of data collection, the research methods included participant observation of the interaction between patient and DN which necessitated the presence of the researcher in the patient's home. The timing of first visits was unpredictable and the researcher often arranged to visit with the DN at relatively short notice. Additionally, as the DN and the patient were meeting for the first time with the researcher present, it was felt not to be appropriate for the researcher to seek verbal and written consent from the patient immediately on entering the house.

The approach adopted involved the researcher gaining verbal consent from the patient on arriving at the house after giving a concise verbal explanation of the study. The patient therefore had an opportunity at the outset to request that data from the visit should not be used for the study although none did. When the DN finished the assessment, the researcher reinforced the purpose of the study and explained the written consent form, which the patient was asked to sign (Appendix 7). Written information (Appendix 9) was left in the patient's home. The purpose of this was threefold;

- to allow the patient to read the information after the visit at their leisure
- to inform carers that the researcher has visited
- to give the patients and/or carers the opportunity to contact the researcher or a named supervisor at a later date.

If the patient was considered too ill or not competent, written consent was sought from the nearest relative/carer. A carer gave written consent at one visit and at all other visits the patients gave written consent.

Careful consideration was given to the information supplied. Polit & Hungler (1991) outline the categories of information required to allow potential participants to give voluntary consent:

- the researcher's name and details of where they can be contacted
- a place for the participant to sign to indicate that they have understood the purpose of the study and the nature of their involvement
- participants must be made aware of their right to withdraw and be reassured that a decision to withdraw will not affect their care
- confidentiality needs to be assured
- the language used should be simple and jargon free

(Polit and Hungler 1991).

The content of Appendices 6 and 7 was developed in recognition of these factors. As a professional courtesy, the GP of the patient visited received a short letter (Appendix 10).

Initially, it was thought that written consent from the DN might not be necessary, as the researcher and DN would travel to the patient's house together and return to the workplace of the DN in order to carry out the interview. Therefore, the DNs would convey willingness to participate in the study by their actions. However, in order to satisfy the requirements of the Research Ethics Committee, and to ensure that the key criteria (Polit & Hungler 1991) were met, written consent was sought (Appendix 6) and written information given (Appendix 8).

Munhall (1993) states that in qualitative research it is not always possible to give participants all the information relating to the exact path of the study due to the tentative

and exploratory nature of the research. This study involved the exploration of the thoughts of the DNs who were professional colleagues of the researcher and therefore sensitivity and diplomacy on the part of the researcher was essential. It was considered that the emphasis on knowledge and decision-making in the title of the study could potentially be off-putting to participants. For patients, the title was long and complicated and for DNs the emphasis on knowledge could be perceived as threatening. A short working title was therefore used for materials given to participants:- “The work of district nurses - first assessment visits”.

3.11.2 Beneficence, non-maleficence and justice

It is essential that participation in a research project yields more good than harm for those involved (Morse & Field 1996). Whilst the proposed study was unlikely to personally benefit the patient or the DN, it was hoped that greater understanding of this area might in future improve care for patients and contribute to the design of educational programmes for DNs.

The promise of confidentiality was contained within the written information and was given verbally during the initial contact and at the start of interviews. Participants’ identities were concealed using coded identification (a number) on written data although the large sections of data contained within the following chapters may make identification of participants possible. For this reason the DNs were invited to read and discuss the interpretation of the data as presented by the researcher. This also formed part of the data analysis process, the audit trail, and was an important method of ensuring the trustworthiness of the study. This is discussed in greater detail in Section 3.15 and Chapter 7, Section 7.2.7.

3.12 Organising ethnographic data

As data analysis was undertaken on a part time basis it became clear that in order to capture the interpretation of the data and the evolving thinking of the researcher, extensive records needed to be kept of the process. The use of analytic memos and story lines is discussed in greater depth in Section 3.13.2.

As the analysis continued and themes started to emerge there was a need to consider further the use of the word processor and software for the storage and retrieval of the

emerging themes which would allow ongoing development and refinement. The increasing availability of software packages, which can provide assistance in organising data, thus facilitating data analysis, is noteworthy.

Literature offers contrasting opinions about the utility of such software in qualitative analysis. Proponents argue that in addition to the advantages of storing large volumes of data, the flexibility to add new codes coupled with powerful search facilities and the capacity to view data within its context at any time is vital to data analysis in qualitative research (Tesch 1990; Dey 1993; Richards and Richards 1994).

Conversely, there are arguments that the use of a software package removes some of the intellectual work of analysis and could result in flat and uninteresting results (Becker 1993; Hammersley and Atkinson 1995). Two software packages were explored to evaluate their suitability - Ethnograph and NUDIST.

Ethnograph, developed by qualitative social scientists, utilises an approach based on coding sections of text. Attaching codes to sections of text remains the intellectual endeavour of the researcher and Hammersley and Atkinson (1995) suggest that this process is no different to manual techniques for identifying and retrieving sections of data. They suggest that even in using such a package, the researcher must invest time conceiving relevant codes. The advantages of Ethnograph include greater flexibility and sensitivity by allowing the researcher to retrieve sections of coded text quickly thus facilitating constant comparative analysis (Hammersley and Atkinson 1995; Hamill and McAleer 1996).

A major disadvantage of Ethnograph in relation to this study was the fact that it operates on a DOS rather than Windows computer environment. Transfer of data from Windows based applications for use with Ethnograph involves re-typing sections of data (Hamill and McAleer 1996). As the researcher had access to Windows-based computing facilities and significant amounts of textual data had already been prepared, it was reasoned that Ethnograph did not provide significant advantages over those currently available through a good word processing facility (Hammersley and Atkinson 1995).

The researcher attended a workshop to learn how to use NUDIST, a package developed in Australia, which can move the analysis process beyond that provided by textual packages such as Ethnograph described above. Nudist allows the analyst to establish relationships

between codes and construct a series of hierarchically ordered trees (Richards and Richards 1994). As such, this package can potentially provide a link between the processes of coding, retrieving and analysing data (Hammersley and Atkinson 1995; Morison 1995).

NUDIST Version 4 was available in Windows format and in the researcher's academic institution, however, a decision was made not to use this package. Practical application demonstrated that the requirement to assign numerous specific codes to very small sections of data was inappropriate to the rich and integrated data that had been produced (See Chapter 4 for examples). Also there were no advantages to meeting the aims of the study by building the taxonomic arrangements within the data provided by NUDIST. Hammersley and Atkinson (1995) argue that the ethnographic researcher must consider carefully the advantages of such an approach and highlight that it might not be appropriate in many cases:

“Whatever merits are to be found in computer applications, we must recognise that they only provide adjuncts to the sociological or anthropological imagination. They certainly do not provide ‘automatic’ solutions to the problems of representation and analysis. Understanding and interpretation are the outcome of the interactions between the ethnographer and the data, which are themselves constructs. There is no mechanistic substitute for those complex processes of reading and interpretation” (Hammersley and Atkinson 1995 Pg. 203).

As the database was considered manageable and due to the reflexivity required in such a study, it was decided that the cut and paste facilities of the word processor would allow the researcher to construct categories following the process of open coding.

3.13 Inductive data analysis

This section describes the analytical approaches utilised to address the aims of the study. Induction is the essence of naturalistic enquiry and ethnographic research requires the researcher to be an active participant in the data collection and analysis process (Lamb and Huttlinger 1989). The concurrent processes of reading and writing are vital to the construction of the ethnographic account and discussion of the approaches utilised in this study follow (Section 3.14) (Hammersley and Atkinson 1995).

Data analysis in ethnographic research is a continuous process that transcends the pre-fieldwork phase through to the production of a final written report. As a process, data

analysis is reflexive and embodied in the researcher's ideas and hunches from the beginnings of the research. The reflexive process utilised in the study is discussed below.

Dey (1993) states that:

"...we want to do more than describe: we want to interpret, to explain, to understand – perhaps even to predict. We want to know how, and why, as well as what. The way we do that is to analyse our data. In doing so, we go beyond our initial description; and we transform our data into something it was not" (Dey 1993 Pg.30).

Data analysis in ethnographic research seeks to establish a coherent and inclusive account of the phenomena under study (Tesch 1990; Hammersley and Atkinson 1995) resulting in a rich description. Ethnographic research does not always remain at this level of descriptive account. It can have a characteristic 'funnel structure' where there is movement towards developing explanations and theories. In such processes, the phenomena being studied are collected under more general categories and typologies and theoretical models may be developed (Lofland and Lofland 1984; Hammersley and Atkinson 1995).

The analytical process adopted for this study aimed to illuminate hitherto covert patterns of knowledge and decision-making in district nursing practice. As the study was conducted in the real world of practice the reflexive role of the researcher in interpreting the data throughout was vital.

3.13.1 Reflexivity in ethnographic research

In ethnographic research, the researcher requires to achieve a balance between personal involvement in the research processes and retaining a measure of objectivity. The delicate balance between the critical thinking of the researcher and the interaction of the researcher with the research environment is crucial to the reflexive process (Lamb and Huttlinger 1989). The reciprocal influences that arise from the research participants and the setting coupled with the influence of the researcher go some way to providing a robust interpretation of the data.

"The premise of reflexivity resides within a naturalist paradigm that postulates an interaction between the investigator and the research environment. The dynamic nature of the research process is such that the investigator often becomes a part of the research even if the goal is to remain separate from it" (Lamb and Huttlinger 1989 Pg. 766).

In ethnographic research the researcher is an active participant in the data collection and analysis process (Aamodt 1982). Professional experience as a DN allowed the researcher to view the data collection and analysis from both a professional and research perspective. Gaining the emic (insider) view of the phenomena is an inductive process where data are derived from observations, interviews and direct participant observation. The emic perspective can be uncovered through the development of descriptive themes and patterns from the informant's perspective, coupled with the interpretation of data grounded in the real world of practice. These approaches are relevant to the generation of nursing knowledge where theory can be developed using the informant's perspective thereby leading to more accurate and reliable findings (Leininger 1987).

The researcher came to the study with extensive experience in the field of district nursing. There were particular advantages (and some disadvantages) to the reflexive process of data collection and continuous data analysis in having in-depth knowledge of the procedural and contextual aspects of district nursing practice.

Firstly, in relation to data collection, the researcher did not need to collect volumes of descriptive data about the context of district nursing practice and could focus on data that related to the study aims. A balance whereby the researcher elicited relevant information without missing important data was necessary. The processes involved during periods of observation and at interview have already been described earlier in this Chapter (Sections 3.9 and 3.10). It is important to reiterate that, although field-notes were written up under 8 pre specified categories (Pg. 82 and Appendix 11) derived during exploratory work, during the actual visit the researcher recorded as much detail as possible in a free hand style. When the field notes were constructed the researcher was able to sieve the information and classify it immediately following the visit. Secondly, the researcher was sensitised in the early stages of data collection to important aspects of the DN role such as searching for a main reason for DN intervention and the role of the DN in anticipating future care needs. This alerted the researcher to these insights to the DN role at a relatively early stage of the study.

The researcher also understood the responsibilities of the qualified DN as the caseload holder. Also, the ways in which referrals for first assessment visits were made were familiar. Also understood were the working arrangements DNs might have if they were attached to a group of General Practitioners or holding a caseload where the patients were

allocated on a geographical rather than practice basis. This background knowledge negated the need for the researcher to exert considerable time and energies finding out about the context of district nursing practice. Experience of visiting patients and carers at home also contributed to maximising the opportunities afforded by the periods of observation, as the researcher felt comfortable in this role. Balanced against these advantages was the need to constantly question how what was being observed and heard could enhance understanding of the process of assessment.

The contribution of the personal and professional experience of the researcher to qualitative enquiry is often known as 'theoretical sensitivity' and is commonly associated with grounded theory (Glaser 1978). Personal and professional experience combined with information from the literature contributes to the creativity associated with the continuous approach to data analysis (Strauss and Corbin 1990).

Throughout the study, the researcher was surprised and excited by the new perspectives of first assessment visits which were emerging for her. For example, the processes involved in making the visit work (Chapter 4, Section 4.2) highlighted the complex and largely invisible knowledge base upon which such actions were based. Similarly, the researcher had to constantly question her interpretation of the data to avoid premature closure of the emerging themes. This was facilitated by in-depth discussion between the researcher and three supervisors throughout the duration of the study and the other steps taken to ensure the trustworthiness of the study findings (See Section 3.15 and Chapter 7, Section 7.2.7).

Data analysis in ethnographic research commences at the very early stages of the research and continues throughout to the production of a final report. There are of course inherent difficulties in achieving an iterative process and the interaction between data collection and analysis. This is particularly true in relation to this study which was carried out on a part time basis and presented particular challenges to the researcher in ensuring that the reflexivity, essential to the ethnographic approach, was not lost (Hammersley and Atkinson 1995). Data analysis was assisted by a 10-week sabbatical supported by the researcher's employer following the two phases of data collection. This allowed the researcher to immerse herself in the data and capture the reflexivity required in the analysis process.

3.13.2 Open coding and the use of analytic memos and story lines

Dey (1993) describes qualitative analysis as a circular process that involves describing, classifying and connecting data. Developing thorough and broad descriptions of the phenomena under study is the first step in qualitative analysis. This step starts with open coding which is the process of breaking down, examining, comparing, conceptualising and categorising data (Strauss 1987; Strauss and Corbin 1990).

Coding has been described as:

“...the task of fitting data and concepts together in such a way that conceptualisation is under constant revision” (Bryman and Burgess 1994 Pg. 5).

In the phase 1 stage of data collection, analysis was a largely manual endeavour where the researcher became immersed in the textual data of the interviews and field notes. Each data set was read several times and audio recordings of interviews listened to. This was viewed as an essential first step in the analysis process and allowed the researcher to familiarise herself with the data and to understand the main features (Sandelowski 1995). Text was scrutinised line by line and annotations were made in the margins for each interview and field note. These annotations recorded the researcher's impressions of what the text represented. At this stage of the analysis process, the development of the researcher's ideas was important and the inherent difficulties in untangling different elements of knowledge based on the frameworks presented by authors including Carper (1978) became apparent (Pg. 159/160).

The next stage was to identify the concepts which would facilitate understanding of the data. Extensive code notes were generated for each interview (Examples of early code notes - Appendix 12 & 13). The code notes, based on the first interview and field note data, included the questions forming in the researcher's mind and a 'story line' for each data set. During the construction of the code notes and story lines the researcher constantly moved between the interview and field note data. Ultimately, the field note data were particularly important in identifying categories of 'knowledge in action' (Chapter 5, Section 5.1) but were referred to throughout the analysis process to enhance understanding and to clarify issues raised by the DNs at interview. The development of analytical categories evolved with this process and involved the researcher in constantly revisiting earlier transcripts to

check for meaning. Parallel to this process was the generation of questions which aimed to seek clarification of the emerging themes for the second interview (Appendix 5).

The purpose of generating analytical categories is to create analytical tools that can help to classify salient features of the phenomena under study. Categories must be meaningful to the data and relate to the other categories generated. In ethnographic research, the categories are generated almost entirely from inferring distinctions in the data rather than using any predetermined categorical distinctions (Dey 1993). Once categories had been created and assigned, the next stage was to organise the data around the categories generated. Tesch (1990) calls this 'recontextualisation' of the data. This allows the data to be viewed in the context of the categories generated rather than its original context and the connections between categories to be explored. The categories and themes that emerged from the data are summarised in Table 2 (Pg. 103) and an in-depth description of these is to be found in Chapter 4.

When the data from the second in-depth interview had been collected, the researcher assembled the data set for each DN and the process of analysis outlined above was applied to the whole data set. During this process the categories and themes in Chapter 4 and a typology of DN knowledge in Chapter 5 were refined and further developed.

3.14 Reading and writing in ethnographic research

The researcher came to the study with experience and knowledge of district nursing practice but with only a rudimentary understanding of the literature relating to nursing knowledge and decision-making. The use of literature in qualitative research differs to that in quantitative research where it is normal to conduct an exhaustive review of the literature at the start of the study. In qualitative research, a review of the literature is important in the early stages of the study design to help with the identification of the research problem and the appropriate research approach. Throughout the study the literature should also be utilised to assist in the stimulation of questions during data analysis. It is essential that the ethnographic researcher "...develops a broad, comparative perspective on the literature" (Hammersley & Atkinson 1995 Pg. 241).

It is argued that commitment to a priori knowledge (including the use of existing conceptual frameworks) might suppress the creativity of inductive enquiry (Morse 1994),

and some authors argue that a literature review should not be carried out prior to the study (Glaser 1978). However, from a pragmatic stance, a balance needs to be achieved between starting with no knowledge of previous and current work in the field and coming to the research with fully developed theoretical models (Morse 1994; Holloway and Wheeler 1996). As an experienced DN it was not possible for the researcher to come to the study without prior knowledge of DN assessment. Throughout the study the processes of reading, data collection, analysis and writing were conducted in parallel.

Writing in ethnographic research forms part of the data analysis processes and is linked to the amount of reading undertaken by the researcher. Writing is essentially intellectual work and written language forms an important analytical tool which, combined with the creative use of written sources, enhances the overall interpretation (Hammersley and Atkinson 1995). Ethnographic accounts are normally narrative constructions of the phenomena under study where the writer seeks to illuminate the reflexive relationship between the text and the subject matter. The current study involved writing and re-writing Chapters 4, 5 and 6 several times. The interpretation of data was an ongoing and reflexive process.

3.15 Issues of rigour and trustworthiness

The standards by which ethnographic studies should be assessed are not clearly defined (Lincoln and Guba 1985; Sandelowski 1986; Hammersley 1998). Disagreements exist about acceptable standards and establishing trustworthiness is a source of concern to researchers employing either quantitative or qualitative methods of enquiry. However, issues of rigour are more often questioned in studies within the naturalistic paradigm and Hammersley (1998) suggests that ethnographers are divided, with some advocating that the standards applied to quantitative research are applicable to qualitative enquiry.

However, qualitative research is based on different assumptions from those of quantitative research. Therefore, the application of the concepts of validity and reliability, which are predominantly associated with quantitative research and based on clear relationships between the findings and the properties being measured, may not provide an appropriate basis for the assessment of ethnographic studies. Attempts to apply these criteria to a naturalistic study may amount to self-justification (Sandelowski 1986).

In order to allow the reader to evaluate ethnography:

“The process by which the ethnography occurred must be clearly delineated, including accounts of the interactions among context, researcher, methods, setting and actors” (Altheide and Johnson 1994 Pg. 489).

Ensuring trustworthiness and rigour in qualitative research should therefore be evaluated using appropriate criteria such as those identified by Lincoln and Guba (1985): credibility, transferability, dependability and confirmability. Hammersley (1998) suggested a pragmatic approach that reflects these criteria but can be described in terms of *validity* and *relevance*. Although Hammersley used the term ‘validity’, his interpretation of the term as set within the context of ethnographic research is:

“...the extent to which an account accurately represents the phenomena to which it refers” (Pg. 62).

Hammersley argues that ‘validity’ as an accurate representation of the phenomena under study is underpinned by the assumption that knowledge can never be certain but that knowledge claims can be judged in terms of their likely truth. Hammersley proposed that establishing truth-value and rigour in ethnographic research requires the researcher to demonstrate the relationship between the approaches adopted to ensure the truth-value and the relevance of the findings to public knowledge.

In relation to this study, a number of steps were taken to ensure that the processes adopted to the data collection, data storage and data analysis were rigorous, visible, and could ensure the trustworthiness and validity of the findings. The researcher wrote up the field notes for each observation visit on the day of the visit. This was to ensure that the ‘picture’ and detail of the visit were fresh and clear in the mind of the researcher in order to capture as much detail as possible. Additionally, the researcher listened to the recorded interviews as soon as possible after the interview to sensitise herself to the content. The researcher undertook transcription of the interviews with some secretarial assistance. All transcribed interviews were scrutinised and checked for accuracy by the researcher. The data were stored in computer and paper format and a simple numerical identification system used to identify the DN and whether the extracts were from the first or second interview (Eg. DN 1:2 – DN 1, second interview).

Rigour is also enhanced by ensuring that the data analysis techniques adopted for a study can be audited (Altheide and Johnson 1994). Sharing interview transcriptions and field

notes with the three supervisors assisted with the audit process and that of confirming the study findings. These data formed the basis of some supervision meetings where the researcher discussed her interpretation with the supervisors and this then helped in refining the interpretive process. Furthermore, the code notes and story lines developed for each DN were shared with the supervisors and were subject to scrutiny and discussion. The findings presented in Chapters 4, 5 and 6 contain extensive data extracts from the participants to illustrate how the analytical conclusions were drawn. The supervisors also reviewed several drafts of each Chapter within this thesis and through this process, challenged the researcher to develop the interpretation of the data. A colleague, who is an experienced researcher, also scrutinised the data for one participant and confirmed the emerging themes. To this end, interpretation of the data was subject to scrutiny and audit throughout.

In addition to the measures outlined above, the researcher ensured that the study participants were given the opportunity to comment on the credibility of the findings and their potential use in district nursing practice. As this process was carried out during the latter stages of the study, discussion of this important step in ensuring the trustworthiness and rigour of this study is included in Chapter 7, Section 7.2.7.

CHAPTER FOUR: THE ASSESSMENT PROCESS IN DISTRICT NURSING PRACTICE

4.0 Introduction

This Chapter presents the main categories and themes that arose from the interview and observation data. It is an interpretative account of the work of district nurses relating to first assessment visits and seeks to illuminate aspects of the assessment process. Whilst the emphasis on the assessment process is clear, elements relating to knowledge and decision-making, though less obvious, are discernible. This Chapter sets the scene for Chapter 5 on knowledge and decision-making and the case study presented in Chapter 6.

The data presented here offer insights into how the DNs collected and interpreted information about the patients and their home circumstances and the close connection of this process to building a relationship with the patient and carer. Anticipating present and future care needs of the patient was an important function of the first assessment visit and there were a number of factors which impinged on this process.

Table 2 provides an overview of the five main categories and themes. Examples are given to support the account.

Table 2: Major categories and themes to arise from data

Category	Themes
4.1 Building the bigger picture	Looking beyond the referral task
	Assessment as an ongoing process
	Beyond the boundaries
4.2 Making the visit work	Giving the right impression
	Establishing trust and rapport
	Using friendly approaches
4.3 Making sense of the evidence	Scanning written information
	Observing the context
	Setting the agenda
	The main thing - 'managing'
4.4 Determining present and future care needs	Managing present care needs
	Family care
	Facing the unexpected
	Keeping a foot in the door
4.5 Working within the constraints in district nursing practice	DN as gatekeeper
	Changing priorities
	Left feeling helpless

For clarity, context in this study, relates to the circumstances which affect the patient; the impact of the illness on the patient's current situation; the environment in which the patient lives; and the social/emotional support available. Additionally, it is taken to mean the influence of the available resources and working patterns of the DN.

4.1 Category One - Building the bigger picture during assessment

In this section, the process of building the bigger picture during first assessment visits is described. This description focuses on the emphasis placed by the DNs on the need to establish an 'holistic' impression of patient's and carer's situations whether visiting was likely to be on a short or long term basis.

Building the bigger picture during assessment involved 3 elements;

- looking beyond the referral task
- assessment as an ongoing process
- beyond the boundaries

4.1.1 Looking beyond the referral task

The DNs differentiated between the reason for referral which was normally framed as a task, and the broader components of patients' and carers' lives. The search for information beyond the reason for referral was striking:

DN 11:1 "I think you obviously want to look at not just the initial referral reason ...you are looking at other things as you go along - are there any complications? ...just whatever you can pick up"

CK: 11:1 "So although you've got referral information...?"

DN 11:1 "You are looking beyond that definitely. You are looking way beyond that". (All said very firmly)

The referral information received by the DN may have been given verbally or in writing, by the General Practitioner or a hospital based nurse. Written referrals can vary from structured discharge forms to scraps of paper or notes written in a diary. None of the twelve visits observed was preceded by structured written referral information. The

referrals were made verbally by telephone or in the form of a short written note from the GP. The referral received by the DN was framed as a task; for example, 'wound dressing' or 'assess for bath' (Table 1 Pg. 77). The DNs were clear that whilst this merited some of their attention, the assessment task itself was not the main focus of the visit. There was consensus that the DN herself should define the nursing problems rather than the person making the referral:

CK: 11:2 "... Do you think the given reason for referral influences the assessment when you go for the first time?"

DN11:2 "...certainly yes when you first go in that would probably be the first thing you would look at but then really that becomes secondary and you are looking more at everything...the whole general picture rather than ...I mean quite often you get an initial reason for a referral and it turns out to be something completely different when you get there...if you don't have an accurate referral in the first place which very often you don't".

The referral information did drive part of the search for further information and drove some actions such as completing a wound dressing. However, DN 1 was clear about her role in relation to the referral information:

DN 1:2 "...I often find that the reason for referral tends to be very task orientated...like 'assess for a bath'...my thoughts are I'll go in and assess the whole situation and (see) whether that is a priority to the patient...if somebody says 'assess for a bath' I quite often say to them well I'll do a general assessment because there may be other issues that we pick up on that are appropriate at home...I'll keep an open mind about that, I'll go in and see what I think..."

The need to gather information from different aspects of the patient's life was clearly identified by all the DNs. This is illustrated in the following quote which is representative of the views of the DNs:

"... if you're there to dress their wound, you're not only there to do that task, inverted coma's.... You're there to assess the patient's needs, not only the patient but the carers' needs as well...I am looking at their physical, psychological needs and the environment and how they communicate. You are not just there to dress a wound but to see how they are managing their activities of living" (DN 2:1).

The necessity to consider the patient's and carer's needs in a range of areas, and the impact of their environment on their abilities to cope with daily living, identifies the process of assessing and managing a wound as both an individualised (particular to this patient/carer) and comprehensive (broad based) activity.

The DNs were clear that their role involved looking beyond the task and they expressed a degree of resentment towards prescriptive referrals. The responsibility and accountability of the DN in relation to identifying problems was evident.

The intention of prioritising needs from the patient's perspective permeates the data and the DNs gave a variety of examples where the patient had needs to be met over and above those identified by the referral information. Resistance to following a task-based assessment was clear. The DNs identified their assessment skills as responsive to the needs of the patient and carer in their own home. A purpose of the first assessment was to make judgements about the condition of the patient and/or carer so that informed decisions could be made about how needs should be met.

If visiting was likely to extend over a period of time, the DNs paced their assessment and were sure that the first visit alone could not provide an immediate solution for all the patient's problems. They knew that the referral task may or may not be significant in the real world situations they encountered.

Where the patient had more complex needs, the DNs identified that more information prior to the visit would have been useful and the situation commonly cited was that of palliative care:

DN 1:2 "If it's for instance a terminal patient, say if the man needs a dressing on his bottom....the information that would be useful is about pain control, who is in the house so that I would know what I was going into in that instance...if somebody is very ill I would need to know a lot more information".

Psychosocial and contextual information was required over and above that normally provided in a referral to allow the DN to be prepared for the visit ahead. Although the nature and amount of referral information was viewed as potentially problematic, in cases where patients had more complex needs it was recognised that to make the referral information patient-centred was difficult:

DN 3:2 "So I think it would be good to have more information (on referral) but on the other hand, I don't know how it would work and even then would you get the right information you wanted? Bearing in mind ...sometimes it takes 3 and 4 visits to get to the nitty gritty...how can you possibly summarise that in a paragraph to hand over to give meaning to somebody's first visit?"

DN 11 identified the impact of the information revealed by the context in helping the DN to look beyond the task:

“I think visiting somebody at home is completely different from seeing them anywhere else. I’m trying to explain why that is and I’m finding that quite hard... I think you know it’s the old cliché about people being themselves at home though, but they are, you see the real people at home as opposed to even say in the surgery here ...you have a chance to look for family things...family problems or whatever. Not even just problems but how everyone fits in to the relationship and to look at their surroundings even with regard to a wound, have they got bathing facilities for example, even just simple things like that - what state the house is (in) ...” (DN 11:1).

The relationship that existed between family members was important to the DN. Throughout, the DNs highlighted the impact of the family and this issue is explored in greater depth in Section 4.4.2.

In addition to looking beyond the reason for referral, the visit could involve looking beyond the information given by the patient and/or carer and the context. DN 1 highlighted possible approaches to the visit to a lady for general hygiene assessment:

“...it’s about looking further than what they say. For instance he’s saying to me everything is fine well I could easily just say ‘that’s great’ and off I go but in fact it’s about recognising...picking that cue up from her, he’s got a sore back, picking up that she probably isn’t the easiest person to look after, he’s doing it all on his own, knowing that, trying to find out who else is there, is there a home help, no he doesn’t want one. It’s about taking all that in and... I think it’s easy to say if you’re managing ‘off I go’. It’s about looking further and stopping and thinking about ‘can they really manage?’” (DN 1:1).

DN 1 outlined the complex processes involved in looking beyond the task, identifying that if she took things at face value her job could be quicker and easier. She identified the scope of the information needed and the questions raised by what she was seeing and hearing. With regard to the example above, DN 1 thought that there were some consequences of caring for his wife that were impacting on this carer, although at this time she was unsure of the full extent or their effect. ‘Looking further’ was an active process informed by the knowledge base of the DNs.

There were differences identified in relation to how ‘big’ the picture needed to be. The amount of information required was dependent upon the nature of the task and the care required. The more straightforward the task was, as in assessing a surgical wound where

the process of healing was predictable, for example, in a young fit patient and uncomplicated surgery, the less information was thought to be necessary:

“... it depends what you are going in to assess if it’s a wound that’s perhaps easier but if it’s a general assessment, a terminal visit or something like that I guess you have to assess all sorts of factors. What exactly the family dynamics are, how much knowledge they’ve got of their condition, what services are already in place, how much help they are actually wanting, if they are willing to ask for help and just what you can offer. If it’s a wound I think it’s perhaps easier. A straight forward surgical wound on a young person is probably easier to assess and is probably not as time consuming” (DN 8:1).

DN 3 reported similar considerations and potential differences in approaches to assessment:

“...if it was a first visit and it was going to be an only visit maybe just to do a wound check post operatively or something I probably wouldn’t go into all these issues of his social aspects of care and all this kind of stuff. If it was just a young person and needed, I don’t know, a stitch removed after they had had a mole removed...I wouldn’t obviously perhaps explore quite so deeply” (DN 3:1).

The individualised nature of first assessment was reflected throughout the data where the DN collected information from a range of sources and tried to formulate a decision related to the context of the patient. This example was drawn from a visit to an 85 year-old lady who required Doppler assessment of her leg to inform future treatment of her venous ulcers:

“I think you have to know to assess the person as a whole because without assessing that whole person - you cannot make up a whole care plan for them. Because if Jeanie could not do her own cooking...if the house was shambolic...(if) it wasn’t clean...we were looking at a whole different scenario. I mean she was well fed...she was not malnourished...we weren’t looking at her struggling with bandages round her ankles...she was in a warm place...I mean her social circumstances.... are very important...they affect her whole well-being” (DN 8:1).

Doppler assessment is a structured task which could have been regarded simply as a procedure. However, the DN considered the social circumstances of the patient and related those to the maintenance of the patient’s well being and the healing of her ulcers. Decision-making and care planning was not based on assessment of the task alone but was informed by a broad range of psychosocial and contextual information. In particular, the age of the patient emerged as an important determinant, the older the patient, the more comprehensive the assessment.

When asked what the DN would have liked a student to gain from a visit to an 85 year-old gentleman for bathing assessment DN 3 said:

“...hopefully a sense of holism...that I’m not really just interested in ...his skin for his hygiene needs but...trying to (get) a wee flavour of getting the whole picture as much as you can, as much as anybody will let you see” (DN 3:1).

This example acknowledges that looking for the ‘big picture’ depends on the information that is available from the context and that which the patient is willing to share.

The data has revealed that assessment involves looking beyond the referral information and looking further than physical problems to psychosocial problems. The information given by patients and carers, whilst crucial, was not always taken at face value with the DN trying to glean information to formulate her own decisions. In this study, a range of factors including the age of the patient, their social circumstances and the anticipated complexity of the patient’s illness influenced decision making by the DN. The DN also had to determine how much information was required at the first visit to help her decide what problems must be dealt with there and then. These factors illustrate the complexity of the assessment process and the necessity for this process to be ongoing in cases where further interventions were required.

The DNs, from these accounts, know that the referral may not tell the whole story. The assessment process involved recognising and seeking out salient features from the physical, social and contextual aspects of the patients’ and carers’ lives. Looking beyond the referral task and the information given by the patient suggests a level of experiential knowledge about the complex task of information gathering and a recognition of the inter-relatedness of the situation, context and the patient’s illness.

4.1.2 Assessment as an ongoing process

Assessment as a process involves estimating the current situation of the patient and/or carer, the purpose being to allow nurses to evaluate the patient's condition and form judgements (Crow et al. 1995). Where the DN was likely to visit the patient on an ongoing basis, it was recognised that gathering information about the patient's problems could be paced and built in to that continuous process.

The DNs knew that the situation of patients was likely to vary and their understanding of the circumstances at the first visit was based on the situation at that time. This understanding was therefore provisional and specific to the first visit. This did not mean that the information at the first visit was not important, rather, that the situation and the thinking of the DN evolved and constantly changed as more information was gathered:

"I don't think you can take everything in on a first visit. I think you have to assess people more than once and it gets very complicated because your ideas change on a second assessment about what you should be doing and who you should be asking for help" (DN 4:1).

This extract implies that DNs 'pace' their information search, an important strategy for professional practice that may help to avoid premature closure on the part of the nurse in relation to identifying the patient's problems. Assessment as an ongoing process was also linked to skills of interpreting the information collected. As DN 1 identified, collecting information was only one part of the process. Interpreting and checking the validity of the information was complicated and also an ongoing process:

"... first assessment visits can be complex and there is a lot of information gleaned from the visit, often it's not completely correct information and it does take two or three visits to actually think about what was said, what's the family's interpretation of what's going on from yours and it's about helping them with that but I just feel that I don't think you can underestimate how complicated it is" (DN 1:1).

At a first visit, the DN was actively looking for information. Where visiting was undertaken over a period of time, over-familiarity with the patient and their situation could become problematic.

“...the more difficult ones are the patients you see frequently because they are the ones you don’t see problems. You see problems on first assessments but it’s people you are going to regularly on frequent visits and then a stranger comes in and says ‘well why didn’t you get the OT’? ‘why didn’t you ask this’? and then you think well, why didn’t I think of that?... because you become familiar with your surroundings and with the patient” (DN 4:1).

The first visit required heightened awareness and sensitivity to the salient issues that were impacting on the patient’s life. Familiarity with the situation might reduce the awareness and sensitivity to information and cues provided by the patient and context by the DN.

Where the needs of the patient were not clear, the search for information as an ongoing process was vital. DN 1 was asked to visit a lady for general hygiene assessment. The picture presented by the patient, carer and the context was confusing to the DN who arranged a subsequent visit to assess the patient’s ability to bath herself before making decisions about future nursing interventions:

“... so I really need to go back and try to sort out what is the main thing in there, it was difficult.... You do get an awful lot (of information) and (that’s) why you cannot make a complete assessment the first day you go in” (DN 1:1).

Observation of this visit by the researcher confirmed that a confusing picture was presented by the patient, carer and cues provided by the context. Despite a thorough search for information the DN was unsure of the patient’s and carer’s needs and decided on a course of action to return and go through the bathing process with the patient the following week to try to resolve her uncertainty. This visit is discussed in more detail in Chapter 5, Section 5.2.2.

The process of building a relationship with the patient seemed to run in parallel to the process of building information (Section 4.2).

“...just relating to a patient in as much as you know getting their background and...all this sort of thing. I mean you gradually sort of build this up as you go in” (DN 10:1).

The first visit was viewed as different from and more difficult than subsequent visits. Where visiting was likely to extend over a period of time it was considered to be a beginning rather than an end in itself. The DNs sought to achieve a balance at the first visit, a balance where the needs of the patient could be identified, prioritised and met by

gathering sufficient information to inform decision-making and subsequent actions. Pacing the collection of information was fundamental to this activity.

4.1.3 Beyond the boundaries

It was acknowledged that there were limits to the information which *could be* and *should be* collected at the first visit. Collecting information from some areas of the patient's life was viewed as inappropriate at the first meeting. The amount of information that required to be collected related to the complexity of the situation and the patient's predicted needs.

Collecting enough information to secure a picture of the patient and their situation, balanced against collecting information for the sake of it, suggested that assessment in DN practice was a responsive and individualised activity open to individual interpretation. Although the DNs were required to complete standardised documentation for each patient, their approaches to assessment varied.

Despite the importance attached to the relationships within the family, DN 9 felt it could be intrusive to explore family dynamics in any great detail at the first meeting:

"...on a first visit I probably would not go into family dynamics too much. I think that on the first visit it's really trying to get a general picture. I don't think that you are going to get everything on a first visit..." (DN 9:1).

Throughout the interviews the DNs alluded to the importance of building a relationship with the patient and family. Building a picture of the patient's circumstances was an ongoing process based on mutual trust. DN 2 explained her decision not to explore with her patient that the patient's mother was nearing the end of life. The patient had given the DN this information but she still felt it was inappropriate to explore the issue further at the first meeting;

"Don't think the first visit is sometimes appropriate (to ask some questions), like she was telling me her mum was terminally ill em.... and that's something that you would maybe want to discuss with her, although it sounds as if things (death) might be imminent with the mother, maybe if I was going back, well I am going back, I would ask 'how are you coping' and em, what sort of support will you have, just the sort of support that she has and how she might deal with the mother's dying" (DN 2:1).

Other areas that were beyond the boundaries at many visits were issues relating to finances and spirituality/religion. Ross (1995) explored nurses' perceptions of the spiritual aspects of care and suggested that although the role of the nurse in giving spiritual care is recognised, that many nurses 'feel inadequate in this regard' (Pg. 466). Difficulties in addressing the religious and spiritual aspects of care may relate to a lack of knowledge and understanding of the concept by the nurse (Ross 1995). A DN may therefore lack appropriate questions within her assessment framework. Not including spiritual/religious issues in assessment could be a matter of judgement about intrusiveness but may also relate to lack of understanding and/or skill in assessment.

DN 7 identified that she based her judgement about whether to pursue issues relating to finance on her observations of the situation:

"...I think I would sort of maybe enquire about these sorts of things (finances) as time goes on if there was a need. I don't know if I would actually do that with everyone if I did not think there was a need...It's a bit like being inquisitive for the sake of it..."

In relation to the patient visited for assessment of a chronic wound, DN 7 thought that it was unlikely that she would ever pursue the area of finance:

"...she's fairly comfortable but if it was someone who was living in social deprivation then I might of, from what she was saying...I don't know if I will broach that subject with her in particular, I don't think I probably will broach that subject because I feel she is comfortable enough, but if the scenario had been different then I might have" (DN 7:1).

Where the patient's needs were complex and continuing visits were likely, the DNs thought it was important to avoid a first visit becoming an 'interrogation'. DN 8 described a visit to a man who required palliative care who, although he had no immediate needs for physical care, was to be visited the next day. When asked why she made this decision she responded:

"...I wasn't fully convinced that yesterday I had gleaned everything that I required...I felt that I had done enough yesterday that I had explored enough. I was trying to make myself known to him and available to them (patient and wife who was main carer). I think when you are delving quite deeply into somebody's personal life quite deeply on a first visit...sometimes you can't do it on that visit alone. I used the excuse this morning that I'll bring up a mattress for your bed and that will make it easier for you..." (DN 8:2).

In this situation the DN avoided overloading the patient and carer with the search for personal information at a difficult time and created an opportunity to return in the near future. The sheer volume of information required also placed exploration of some issues beyond the boundaries. For example, patients and carers requiring palliative care may have a number of healthcare professionals visiting and the DN was conscious of not asking the patient to repeat information several times.

Areas considered beyond the boundaries at the first visit related to the perceptions and values of the DN. There was recognition that family dynamics are often complex and thorough exploration on the first visit was viewed as potentially intrusive. This also applied to finances, where had social conditions been poor, the topic would have been explored.

4.1.4 Summary - Building the bigger picture in district nursing

Building the bigger picture of the patients' and carers' situation was viewed as fundamental to the assessment process whether visiting was likely to be carried out on a short or long-term basis. Observation of patients within their environment was a powerful source of information and there was acknowledgement that it was inappropriate to overload patients with requests for information at the first meeting. A delicate balance had to be achieved between building the bigger picture and avoiding overstepping the boundaries. The first visit was individualised with the DN having to determine what information was needed. The approach to gaining sufficient information on which to base an assessment had to be flexible and could not be too rigid.

Some DNs preferred to undertake first visits (normally those they anticipated would be straightforward) with relatively little prior information. Observations confirmed that the DNs did not generally write down information about the patient in the home or use the Kardex as a framework during the visit. Where they did, this was restricted to factual items such as demographic details or medications. One exception was the patient visited who had a Doppler Assessment of her venous ulcers and the DN used a specific assessment tool to record information relating to the procedure. The focus of the DNs was the patient and establishing a climate conducive to facilitating the search for information.

The case or reason for referral was an indicator as to the type of information required by the DN. Whilst the referral information gave a starting point for the visit, the DNs were clear that the scope of their information search far exceeded the reason for referral.

Throughout, they identified situations where the reality of what they found at the visit did not relate to the information given prior to the visit, and in a sense they treated prior information with an open mind and healthy scepticism. In some cases the patients had many more needs than might have been expected from the referral information whilst in others, reality was less complex than anticipated.

Gathering in-depth information was viewed as inappropriate at some visits where the DN was unlikely to visit on more than a few occasions. Where visiting was unlikely to extend beyond one or a few visits, the DN set about the process of building the picture in a way that would confirm her judgement that there was no further need for intervention. Conversely, where patients had complex needs, the DN gleaned information from a range of sources to determine how much help was required. Regardless of whether visiting was likely to be one-off or extended over a period of time, the DN tried to build a picture of the physical, psychosocial and contextual components of patients' and carers' lives.

Building the bigger picture, whilst avoiding the first visit becoming an interrogation, involved exercising judgement about how comprehensive assessment **could** and **should** be. The boundary between acceptable questioning and enquiry that could be perceived as unacceptable interrogation was recognised. It would appear that knowledge underpinning DN assessment practice is derived from theoretical **and** experiential sources and is therefore a mix of formal and informal theories (Eraut 1994). The DN has to decide what information is required in a particular case to allow her to determine what the problems/needs are so that appropriate interventions can be planned.

4.2 Category Two - Making the visit work

The first meeting between the DN and her patient was described in detail throughout the interviews. The way in which the DN approached the first visit was directed towards making the visit work and had three main elements;

- giving the right impression
- establishing reciprocal trust and rapport
- using friendly approaches

4.2.1 Giving the right impression

The DNs were sensitive to the impact of the first contact with their patients and identified how they tried to give the right impression. DN 3 was asked what she thought were the most important things when meeting the patient for the first time:

“...I think the most important thing is to give the right impression. You want to appear professional, you want to be able to identify yourself so people know who you are. ...today I phoned up before I went so the man knew I was coming, so that was good. He knew what time to expect me so he didn't think who is this appearing on my door, so I think that is a good first impression to make...” (DN 3:1).

DN 3 and her colleagues were sensitive to their position as guest in the patient's home and viewed actions such as these to be courtesies to patients and families. DN 3 demonstrated awareness of the potential impact of the first meeting for the future when she said:

“I think you can do an awful lot of damage or an awful lot of good on a first visit and you have got to be really aware of that because people...it's very subjective ...but I know when I meet somebody for the first time I scrutinise them. I just always imagine well if somebody was looking at me like the way I'm looking at them, I'm very aware (of) that...trying to maintain this approachable appearance but also very aware that I am wearing the uniform of my profession and I really should be seen to behave and act in a certain way” (DN 3:1).

Knowing how to act as both guest and professional in the patient's home has been identified as an essential attribute of the DN (McIntosh 1981). This example highlights the level of awareness of the DN in relation to giving the right first impression and the possibility that the visit could go well or not. DN 3 identified certain personal and

professional expectations that she had of herself. She was conscious of being able to influence how the visit unfolded.

DN 4 was conscious of not using her position to invade the privacy of the patient's home and described the impact made by the DN from the time the patient opened the door:

"... this sounds really complicated but from the minute you knock on the door to that minute they open the door and look at you - that's when it starts (the relationship) and you could be wrong you know from that minute"

CK: "You mean wrong in terms of...?"

"How you look, what you say, how you stand, do you barge in? Do you push past him? There is lots of things, do you wait and do you say 'hello I am Janey the District Nurse, can I come in? So it's really right from the minute they open the door...they are a stranger to you and you are a stranger to them...I think those first two moments are important...the way you communicate with them is very important - even the tone of your voice - there's nothing worse than if the tone of your voice is wrong..." (DN 4:2).

DN 4 understood how her non-verbal and verbal behaviours might impact on the patient at the first moment of meeting. The immediacy of this was linked to the need to establish a relationship with the patient in order to allow the process of identifying and meeting needs to begin. Knowing that it is important to approach a patient in a certain way raises questions about how such learning occurs in DN practice. DN 4 had 25 years of experience and held a DN certificate (Table 1, Pg. 77). Apart from a range of professional updates she had not embarked on accredited programmes leading to a degree level qualification. This would suggest that knowing how to approach a patient at the first visit was mainly drawn from social rather than theoretical learning.

DN 11 suggested that in addition to her appearance and how she presented, giving the right impression related to the information she could give her patients:

"I think first impressions are important...it gives them confidence that you know what you are talking about and (helps to) get their confidence really".

CK: "You talked about first impressions and how important that was. How do you think you do that?"

"Well obviously the very first thing I suppose is appearance you know tidiness, you wouldn't go in, unless it's a windy day of course like today (laughter) but also I think in your information that you are giving (you need to) make sure you are able to answer

questions as accurately as possible and give information, instil confidence. I think that's vital really on a first visit" (DN 11:1).

After the first visit or between visits, DN 8 thought that families and carers needed to know what support was available. She wanted them to feel comfortable about contacting her if needs arose:

"I think it is very important that on that first visit you do give the right impressions. That you are available and that you will help as much as you can and that they've got to ask and that they have a contact number for you and that if there is anything when you go away they are unsure of, that they get back in touch with you" (DN 8: 1).

Giving the right impression had different meanings for the DNs. Expectations of themselves as professional nurses were identified but giving the right impression for some was more complex. It related to their own knowledge and value base and ability to meet the needs of patients for information. Availability to support patients was vital and this may have related to the individual perceptions of the DN role. The DNs, each in their own way, set about giving the right impression at the first meeting with the patient.

4.2.2 Establishing reciprocal trust and rapport

The DNs made strenuous efforts to establish a good rapport with their patients and reciprocal trust was viewed as essential to this process. The DNs identified and displayed a range of strategies used to gain the trust of the patient. Gaining the trust of the patient was an active process involving conscious deliberation about how to foster a trusting relationship at the first visit. If the DNs only visited once they wanted to ensure that the patient trusted them enough to contact them in the future.

The need for reciprocal trust is illustrated in this example where DN 8 uses the phrase 'breaking down the barriers'. She identified that her position as a nurse could create an obstacle to the nurse/patient relationship. She needed to ensure that the patient would carry out her advice:

"I find an assessment quite a difficult visit in a lot of cases, you are going in and these people have never met you. You're going in as the nurse and it's just breaking down the barriers - yes you are still the nurse but you have got to break them down to a point that you trust each other. That they trust that I can go in and say 'now you will elevate your leg won't you?' Somebody said I was bossy - I don't want to come over as bossy but that

they trust what I say is right and they will do it - and I trust them to do it in their own home" (DN 8:1).

There was awareness that the DN had a powerful position and DN 8 wanted to establish a balance of trust. DN 7 described establishing a partnership with the patient. She was also aware that she needed patients to carry out her advice:

"...a partnership, trying to be equal – to come and go with what obviously would be best for the patient but obviously what the patient wants as well - a good relationship ...a good rapport because ultimately you want their compliance as well, so a give and take relationship" (DN 7:2).

The DNs had strategies for gaining the trust and confidence of the patient and DN 4 said:

"I think probably the first thing is to gain the confidence of the patient. If you are going to someone for the first visit they don't know you and you perhaps don't know them and I think straight away I like to try and get a rapport with them. So, I usually talk about everyday things to start with and try you know, try and sum up how they are feeling so that's probably my first priority...I think you may have seen today, once you start chatting with them they start to give you information you need without you even asking. I mean suddenly you have got quite a clear history of their back ground, how they are, how they are feeling, em you know without even asking. Obviously, you've got to find out how they are feeling at the time, it depends why you are assessing them" (DN 4:1).

Observation of this visit confirmed the claims of the DN who quickly established a good rapport with the patient and had no difficulties getting the information she was looking for. Chatting about everyday things was a strategy used by the DNs who aimed to make the patient feel at ease and an equal in the relationship. Trust was also linked to being realistic and not giving patients false hope.

CK: "What kind of relationship do you think you are trying to establish at the first visit?"

"A relationship of trust really - a feeling that I might not have all the answers but hopefully I can pick up on a few things that will make it better. To make sure they know who I am, where they can get me, what kind of things I might be able to offer them...reaffirm confidentiality - anything they say is safe - I'll only tell the Doctor if they want me to. That really I am on their side – that's the feeling I am trying to get over but also trying to realistically say what I can and can't do. That's another thing I've reflected on - its only fair to tell people what you can do and what you can't do because if you lead people up the garden path that's even worse. To go to somebody that's terminally ill it would be the most wicked thing in the world to say, "well never mind we'll soon have you running up that road". So it's an honest and open relationship of trust really. Hopefully the patient and family would feel that they could phone up if they did not want to speak to me face to

face in front of a relative and whatever - that they would know that I would hopefully respect their wishes and do my bit for them" (DN 3:2).

DN 4 eloquently summarised the importance of 'relationship':

"I think we have said and I would say it again that your first visit is so important – it's a stepping stone of your relationship and how you treat your patient. It can be hard work if you get that wrong...it really is not anything to do with what you are going to do - what treatment you are going to give. It doesn't matter whether it's a simple Neocytamin injection or if it is a terminal care, the first assessment is still the most important visit" (DN 4: 2).

4.2.3 Using friendly approaches

Creating a good relationship with the patient involved using a number of friendly approaches that included engaging in general conversation and respecting common courtesies. The DNs were clear that they were trying to establish a relationship that was friendly to an extent as the following typical extract illustrates:

"I think you can be friends up to a point. I think you can be superficial friends and I think you can learn to support but yes we all talk a little bit probably about our lives as well being in that one to one relationship but there is a point where you say 'no'. I think they would quickly lose respect for you and it would put you in a position where...I don't think it works" (DN 8:2).

DN 8 delineated the boundaries of relationship. She identified the need to protect herself from becoming too involved. Keeping some distance was viewed as important as was the recognition that "...you just can't become everybody's best friend" (DN 5:2).

Recognition that the DN had access to information about the patient, which would not normally be available to even a very close friend in a personal context, was identified by DN 3 who alluded to the power that comes from holding or being able to access personal information:

"I think that's quite dangerous - I don't know if dangerous is the right word – it's quite uncomfortable as well...if you do get too close people start to see you as a friend. I think that can be quite a dangerous thing because you have been party to information you would not normally have about a friend, even a very close friend. You know if you have been able to read medical notes and things, normally friends are on an equal power balance...so in a way you can never be friends so I think it's not a good thing to nurture...people don't really want to know what I am worrying about...they have enough on their own plate...so it's never an equal friendship so I know that, I hope" (DN 3: 2).

DN 3 thought that if she revealed personal information about herself that this might impact on the trust the patient placed on her. There was recognition that the DN might impart some general information about herself but this was not viewed as a strategy to achieve an equal friendship but rather about using friendly strategies to make the visit work.

By using friendly approaches the DNs were seeking to foster a useful and meaningful relationship to allow the patients' needs to be met. DN 4 highlighted the dynamic and cyclical nature of relationships in district nursing practice. She identified that very often the relationship was deep but transient in nature. The relationship related to the needs of the patient and/or carer and context in which it occurred.

CK: "What do you think the difference is between a District Nurse patient relationship and a 'friend' sort of relationship?"

"It's a good question, it's so different from hospital nurses I think friendship comes into a lot of it - especially in a community like this where people know you - but it's not the same friendship as your friend or someone you go out with and talk to. It's a different type - it's a much deeper friendship in some ways - and what I often find out which is quite interesting (is that) when you are looking after someone you can form a really quite deep friendship with them. But once the care is finished that friendship is not really there - don't get me wrong you still talk to them but it's not the same friendship as you had when you were actually caring for the family. So it's not the same kind - it's not the same friendship - it's only a deep friendship while you are there looking after them...and then when the care is finished it goes back to how you knew them before which is to say "hello" in the street - "how are you" and things like that.

CK: "So it goes to a more superficial level again?"

"Yes. I think it would be impossible to sustain a deep friendship with them all because you could not do it anyway. What I really find interesting is a lot of patients that you have become quite close to and really had quite a good friendship with them, once that care is over, especially if it's a death in the family and it's someone young or it's been unexpected or it's been a sad kind of death, I find that very often they don't want your friendship after. It's bringing back too many memories of what's happened. I am not saying they would ignore you in the street because they don't but they treat you differently...I think its because they have perhaps lent on you and relied on you so much during that time that when it's all over they don't perhaps need you the same so their treatment of you is different and it definitely brings back memories to people because I met a lady in the supermarket the other day - I haven't seen her for about a year and as soon as she saw me her eyes filled with tears and it's because it's suddenly brought back to them".

This example demonstrates the movement in the relationship that is part of district nursing practice. For some patients and carers, the association with the DN to a very painful experience of their life was tangible.

The very intense relationship, which sometimes existed as outlined above, could make it difficult for the DNs to cope. They adopted deliberate coping strategies to avoid becoming too involved in the lives of their patients:

“...if I feel I am getting in too heavily with a patient then I’ll ask one of my colleagues to go in for a while if I feel that they (the patient) are leaning on me too heavily to the point where I am not coping very well with it or I think they are knowing too much about (me) then I’ll ask somebody else to go in and take over for a while” (DN 6:2).

Avoiding over-involvement with patients and carers was a coping strategy of the DNs for dealing with complex situations in the privacy of a patient’s home.

4.2.4 Summary - Making the visit work in district nursing practice

Making the visit work emerged as a dynamic and reflexive part of the first assessment visit in district nursing. The DNs actively sought to make a good impression on the patient at the first meeting. Strategies for achieving this included how they presented themselves in terms of appearance and interpersonal skills. The realisation of the potential impact on the patient of their first sighting of the DN at the door was a powerful one. Giving the right impression was also related to the knowledge base of the DN as was being able to give patients and carers appropriate and realistic information. Establishing communication channels that would allow the patient or carer to contact the DN for further information or support was viewed as a good impression to give of the service.

Establishing reciprocal trust and rapport with the patient and carer was the basis of the DN – patient relationship. It was acknowledged that because the DN was only present in the home for short periods of time that the DN needed to know that the patient would carry out instructions in her absence. There was a sense of the DNs understanding that they could not expect compliance unless they had gained the trust of the patient and had given them a reasonable explanation as to what they needed to do and why.

Using friendly approaches to establish the relationship was important but differences between the DN/patient relationship and that of a friend in personal lives was clear. This difference was attributed to the balance of power and the access to information the DN had by virtue of her position.

Perhaps an unexpected aspect to arise in this category was the deep but transient nature of relationship often formed between the DN and her patients. A relationship was described that was responsive to patients' and carers' needs in a given context and at a given time in their lives.

The data in this section demonstrate knowledge in use and emphasise the complex knowledge base on which actions are based. Building a relationship in DN practice involves getting to know the patient and knowing how to approach the visit appears to be derived mainly from the experience of carrying out other visits. The theoretical knowledge embedded within these processes is difficult to conceptualise as distinct from procedural and values based knowledge. This would support assumptions that assessment practice is underpinned by an amalgam of formal and informal theoretical perspectives (Eraut 1994; Worth 1999; Bryans and McIntosh 2000).

4.3 Category Three - Making sense of the evidence

The purpose of the assessment process was to collect information on which to base current and future decisions and actions. The DNs collected information from a range of sources and the data highlighted the impact of the context and the observations made by the DN on her judgement and decision-making.

Making sense of the evidence had 4 main elements;

- scanning written information
- observing the context
- setting the agenda
- the main thing – ‘managing’

4.3.1 Scanning written information

Written information was mainly viewed as background and supplementary by the DNs. There were mixed opinions as to whether the opportunity to read medical notes and seek additional information was a useful strategy or not. Some DNs identified that where possible, they would always check out the patient’s medical notes as they gave them a sound basis for the visit and reduced the information search process. Some DNs viewed access to appropriate information about the patient as helpful in preventing the visit becoming an interrogation.

The DNs identified that the referral information could be limited and inaccurate. However, there could be advantages in visiting the patient for the first time with limited information.

DN 8 described how information following discharge from hospital or the patient’s medical notes might sometimes not be available and the possible advantages of this scenario:

DN 8:1 “...sometimes it’s more useful (to go in without additional information) because you are assessing them without any background knowledge. You haven’t read that there is a bit of depression or that there is a family problem...so you are making your own personal assessment without relying on what other people have already decided upon...so you’re in there at the ground...”

Other study participants agreed, noting that visiting with limited information was useful in helping them to avoid making assumptions and to uncover what the patient's perspective really was. DN 1 explained why she liked to get information from the patient rather than written sources:

"...I like to ask them (for information) because I like to know what their insight is to what's going on and also the carer and how they interact with each other..." (DN 1:1).

Very often the reality of the situation that the DN encountered bore little resemblance to the referral information and the DNs had to respond to the information they collected at the visit.

"I think the information is often limited and I tend to have quite an open mind actually when I am going in - be prepared for anything, just from experience realising that information can be limited and sometimes that's the least of their problems...it might be the main problem (the reason for referral) but yes from experience I tend to go in with a very open mind...earlier on in my career I might have been very - 'that's what we are going to do', but now I realise that you could go in and have ten problems instead of this one that you thought you might have" (DN 1:2).

Written information provided a starting point for the visit but the limitations of the information normally provided were clear. During periods of observation it was evident to the researcher that being given wrong factual information, such as an incorrect address, or being given no indication of when the patient needed to be visited by the DN, caused more problems than being given little or no information about the case.

4.3.2 Observing the context

Throughout the data, the powerful cues provided by the context were evident. DN 4 outlined the amount of information she could glean by observing the patient in their home environment. She identified that some information needed to come from the patient but illustrated the significant amount that could be gained from observing the patient and carer in context;

"Obviously you have to find out how they are feeling at the time, it depends why you are assessing them, you know for what reason, but I think you know observation as well. You are watching the patient, you are seeing whether they are in pain or whether their mobility is poor or the surroundings they live in, are they conducive to making life easy? I think with district nursing you tend to take in a lot just by, you know as soon as you walk into the house. Are they emaciated, are they overweight, is their colour poor, do they look tired,

are they sleeping at night? All of this I think you are taking in from the first moment you step in the house” (DN 4:1).

The immediate impact of the appearance of the patient and the environment on the DN was a powerful one. For example, it seemed that good or poor living circumstances significantly influenced the DN’s perceptions of the situation in the household.

Observation involved noticing aspects of the environment which were relevant to the patient’s condition. The DNs identified those aspects of the environment that stood out for them whilst drawing from a wide range of information. Observation, which included the use of all senses, was an active, ongoing process which took place throughout the visit.

DN 8 identified how she integrated observation of the environment at the visit:

“...I mean you do look at everything when you go into the house you learn to look in the bathroom; you learn to have a scout around the kitchen without trying to be nosy. I mean normally if I am asking for a urine sample I do normally ask if I can put it in the bathroom you know the container just to have a bit look without trying to appear too nosy; ask if that’s all right if you have a bag of rubbish its quite nice to say: can I put this in the bin for you because that way you see the back kitchen or go through the back kitchen out to the bin and you can glean quite a lot from that” (DN 8:1).

Observation included the use of vision, hearing, smell and touch to determine the suitability of the home environment of the patient and the dynamics existing within the family. The process started as the DNs approached the patient’s home and they formed impressions very quickly of the situation. Information gleaned from observation drove the search for further information and this was particularly evident from the field notes.

Observation of the situation significantly influenced the DNs judgements and in many instances informed their actions. The relationship between the information gained by observation and the cognitive processes of the DN throughout the visit permeates the data. For example, observation of the home environment, certain characteristics of the patient (age) and the nature of the patient’s illness could result in the DN deciding that complications were unlikely to occur. She might therefore collect less information than in other more complex cases and decide that no further intervention is necessary. To separate the connection between what the DN was seeing, asking and doing in context would be to lose the essence of first assessment visits.

4.3.3 Setting the agenda

The DNs had an agenda in relation to the search for information that focused on the assessment task and the wider aspects associated with patient care. Extensive field notes for each visit captured the sequence of events at the visit and illustrate the integrated manner in which the DN asked for information, carried out the task and acted on cues from the context and patient.

Appendix 14 describes a visit to Mary by DN 8. The purpose of the visit was to determine whether her leg ulcers were of venous or arterial origin by carrying out a Doppler test. DN 8 led the search for information and collected information relating to Mary's physical and psychosocial status. Throughout the visit, both the seeking and the giving of information were integrated with carrying out her task. The agenda was related to both the assessment task and the issues that presented from Mary's circumstances at the visit.

Setting the agenda for the visit could be influenced by the reason for referral as outlined by DN 1:

"...obviously the referral from where-ever it is will tell you a little bit about what you are going into or what you think you are going into, so obviously that's something that's in my mind before I go in, em and it's something that I will look for quite quickly you know try and get round to that quite quickly but of course I mean the situation can be completely different when you get there from what you imagine it might be and then that of course, your priorities change".

DN 1 identified the need to clarify the reason for the visit but clearly states that the reality of the first visit is very often quite different to that expected, making a rigid agenda inappropriate.

DN 1 also outlined some general areas that she would normally include on her agenda at a visit to an elderly person:

"...I quite like to generally see how somebody mobilises because it tends to be frail elderly that's the majority of the caseload so I like to see if they can manage and I like to see what they are, who and what they are supported by at home. And I quite like to see how their memory is so although I often know what drugs and things and what's happened to them you know from case-notes in the surgery I like to ask them that. Em or I might have a letter from the hospital I like to ask them because I like to know what their insight is to what's

going on and also the carer and how they interact with each other. So these are the things that I like to gather in my first visit generally”.

DN 1 identified, in relation to a visit to an elderly couple that some people needed to be persuaded to give the information she was looking for:

“...I think you have to be able to persuade them to talk to you and be able to extract the information that you need, you know... both of them were giving me all sorts of information and it is about trying to bring them round to your topic so that you can get the information you want. I think it's learning how to listen to them...to show you are paying attention to what they want but to also gently kind of get round to what you need to know” (DN 1:1).

At the first meeting there was a need to balance the search for information with an appropriate amount of questioning. The DNs had an agenda for the first meeting that involved collecting enough information but without pushing too far:

“I think it takes a long time to learn interpersonal skills. I think it's something that...some people have naturally but I don't think it comes naturally to a lot of us and certainly I think probably to begin with I found it quite difficult to hit the right level. You don't want to pry or to ask too much otherwise you just get the barriers put up. It's hitting the happy medium that you get the answers you are looking for. It was easy today because she was quite happy to talk but a lot of I mean people don't like you asking that sort of question. How do you manage to cook? Well if you're not cooking then you don't like anybody to ask...” (DN 8:1).

There was recognition that the patient and or carer might have an agenda. Examples were given where the DN and patient or carer had different views about whether or not the patient required a particular intervention although this did not occur in any of the visits observed. Bathing was cited as an area for differing views and the demarcation between health and social care in this area of DN practice remains unclear.

Some of the DNs stated that they used some elements of nursing models to guide their assessment. The most commonly cited model was Roper, Logan and Tierney's (RLT) Activities of Living Model (1996) or Orem's Self-Care Model (1980). Use of an identified model was not adhered to slavishly but gave guidance to their information search. The NHS Trust standardised documentation that the DN had to keep for each patient was based on the RLT framework.

Some of the DNs had adapted existing frameworks to respond to the scenarios they encountered. The influence of the framework (Orem 1980) formulated by this DN to the assessment process is clear:

“I think I mentioned before I was using Orem’s model in my head, thinking what was a self care deficit perhaps that would be a more appropriate heading for the community - self care deficit, what is it what they can’t manage for themselves or bearing in mind you are trying to promote independence and anyway I think that would be better documentation using that kind of a framework and trying to maintain normalcy. What can we do to, this is what would be going through my head, what can we do to get them to maintain a fairly normal way of living - what is it they are lacking - what can we provide - what can’t they do, or if a carer provides it will we be able to maintain normalcy with what the carer can provide and what we can provide...I think that would be a better framework, Orem’s model of care, rather than the one we’ve got (RLT)”.

CK: “So do you think you have that framework in your mind?”

“I am kind of thinking, what is it they can’t, they can’t do, what can’t they do - what is the problem here. How can that problem be solved?...what is their self-care. Why am I here? Why am I visiting?...is it a gap that they can’t manage that we can fill in and doing something for them...if they are not feeding themselves properly - can “meals on wheels” for example fill in that gap...if it’s a self image problem we can attend their pressure sore, try and heal that and get them back to normal that way. I do kind of go through that in my head – I’m maybe not using it formally but well I go through these sort of, kind of stages in my head. What can’t they do for themselves - what can we do? It depends what it is they have got. If it’s a pressure (sore), if it’s a varicose ulcer they have got...that’s quite definite, something to focus on but there are other things that are more abstract” (DN 9:1).

Looking for ‘gaps’ related to the search for the main problems (Section 4.3.4) for which patients required help.

4.3.4 The main thing – ‘managing’

At the first visit, the DNs focused their attention on gaining a picture of how the patient managed to cope with daily living. ‘Managing’, as the main thing, was linked to the physical aspects of daily living but the psychosocial and contextual elements of the patient’s lives were integral to how they managed daily living. The DNs explained how they tried to work out from the evidence available what the patients’ needs were and this was related to their judgements about which aspects of their lives patients and carers could independently manage and those with which they needed help.

DN 1 visited a lady to assess for bathing. She had previously visited the patient a year ago when she decided that the patient did not need assistance with a bath:

DN 1: "Well this referral came from a day hospital and it just asked me...well this lady would like a bath and could I do that. I knew from the address and the name that I had visited this lady previously probably about at least a year ago and obviously my first thoughts was, something's changed. One, she is going to day hospital now which she didn't do when I last saw her and secondly they are asking for help so something has changed in the house. That's my first thought and obviously I need to go and assess them and although I've refused them the service in the past I did say to them at that time I would reassess them if the situation changed and therefore that was what I was going to do. So that's my first thought that something has changed".

CK: "Right, and as you went into the house today, given that this was a patient you had visited before was there anything that was instantly different you felt to a year ago?"

DN1: "Not instantly I have to say. The same situation where the main carer, very laid back in appearance and "Oh I'll manage" that was very much before and em the lady herself not much appeared to have changed immediately by looking at them both. In other words I didn't go into a really stressed household where you know they were definitely not managing".

Prior to the visit the DN had some knowledge of the situation and thought that, as she had been asked to visit again, the situation was likely to have changed. On visiting, her initial impressions were that the patient and carer were managing. As the visit unfolded, the DN found her judgement of the situation changing and experienced difficulties in making a decision about the existing care needs as the picture presented was confusing:

DN1: "I think the main thing was that the woman's husband was very...appeared as though he was coping but in fact I would say he could probably do with a bit of help in some way. Even if it is just to get a break as opposed to any physical help...I had an inkling that she could maybe do more for herself than she initially said and relied very heavily on him and he has got into this thing where he just does everything for her without really thinking about should I?"

The DN illustrated the conflicting picture between what the carer told her – that he was managing – and her perceptions of the situation. Despite asking a range of questions and observing the patient and carer together, DN 1 was not clear what the needs were and talked about the 'main' problem:

DN 1: "Well I think, it appears that the main problem for them is bathing although I would have to query that in that he said 'oh no it's not a problem'. And she was expecting a nurse

to come and bath her today and yet she was sitting in her clothes so there seemed to be a bit of confusion about who was coming...”

CK: “It was about lots of information and the picture kept changing really...?”

DN1: “...it’s about trying to sort that all out isn’t it and deal with what’s important so that’s why I said to her what did she think was the main problem...I don’t know if she had a complete idea about that herself... really. But obviously I get the picture that he’s (the husband and carer) a bit stressed, be that physical or mental, I’m not completely sure, obviously physically because he’s got a sore back, he’s doing things he doesn’t need to do so I need to really go back and try and sort out what is the main thing in there...”

Searching for a ‘main thing’ was an important insight into district nursing practice. Whilst the DNs collected a significant amount of information from all aspects of the patients’ and carers’ lives, there was a noticeable cyclical nature to the process at some visits. The DNs often started their search for information in relation to the referral task. As the visit progressed, they broadened out the scope of their information search to help them build the bigger picture before focusing back to the issues surrounding the referral task. In this scenario, the DN found it difficult to form an opinion about the true situation and subsequently focused her decisions and actions on the reason for referral. She had identified a range of potential other issues which might have been significant to the patient and especially the carer, whom she thought might be stressed and socially isolated by his caring role, but she focused back to the referral task for the next visit.

DN 1 illustrated how easy it would be to assume they were managing and take her leave. Deciding whether the patient and carer were managing was a process which involved collecting and interpreting information and deciding what further information was required to make a decision about future care:

DN 1: “For instance he’s saying to me everything is fine. Well I could easily just say that’s great and off I go, but in fact it’s about recognising that he has got...so picking that cue up from her, he’s got a sore back, picking up that she probably isn’t the easiest person to look after, he’s doing it all on his own, knowing that, trying to find out who else is there, is there a home help - no he doesn’t want one. It’s about taking all that in...I think it’s easy to say if you’re managing ‘off I go’. It’s about looking further and stopping and thinking... ‘can they really manage?’ And so it is worth going back that next time just to see, and yes she may have got in and out the bath no problem and that’s fine but at least then I have satisfied myself that she copes... but I am not convinced at this stage”.

This example highlights the complex process of deciding if and how the patient is ‘managing’ and whether there is a role for the DN in providing future care. The DN

emphasised the complexity of the situation and was focused in her quest to satisfy herself that she had thoroughly explored the situation. The focus on searching for a 'main thing' is pertinent to the assessment process. As the DN collects a range of information about the physical, social and contextual aspects of the patient's life, there are limits as to how many issues the DN can realistically deal with. The identification of a main problem sets realistic parameters on those problems faced by the patient with which the DN can assist and may be associated with the way the DNs pace their collection of information.

In an exploration of doctor's clinical reasoning, Barrows and Feltovich (1987) recognised that clinical problems are often ill-structured and therefore the doctor's reasoning processes are built around a 'temporal unfolding of information':

"Patient problems are ill-structured problems: all the information needed for the solution is not available at the outset; the nature of the problem changes as the investigation proceeds; the approaches that lead to the solution are generally not standardised but are unique to the problem; and the problem-solver may never be certain that a solution has been reached" (Barrows and Feltovich 1987 Pg. 90).

This explanation offered by Barrows and Feltovich sheds light on the paced approach to assessment assumed by the study participants (see also Chapter 6). As discussed above, the DNs recognised that in many cases collecting information was likely to be an ongoing process as the situation they encountered unfolded and changed. The DNs had to decide what actions to take based on the information available to them. They recognised the need to remain open and responsive to new information if and when it became available.

DN 8 visited an 85-year-old lady to undertake a Doppler Assessment of her venous ulcers. When asked what she was looking for in addition to carrying out the Doppler test she replied:

DN 8:1: "Just the state of the house, if it was warm, her appearance. Obviously I did not ask how much help she was getting until well into the visit - I sort of tried to do my task and work in how she was managing, coping and specifically I homed in on what I was meant to be doing. I did try to explain to her what I was going to be doing and my reasoning for doing that".

CK: "I thought you explained it very well actually".

DN 8:1 "Just to find out about her social support and if in fact she was needing more than the specific task I was in there to do which was basically to find out about her leg ulcer".

CK: "So what were your impressions...?"

DN 8:1 "Well it was a clean, tidy warm house. I mean she said she was adequately supported and she certainly seemed to have that. She had specific tasks for her home help. Even in the bathroom when I went through with the urine bottle - it was clean and tidy - there was no evidence of anything anywhere in the house so she was obviously coping and in her personal appearance she was coping as well...For a lady of her age, what was she, 85? - she was remarkably independent. I had expected her to be requiring some sort of input from us. The fact that she was managing to cook and that she was only depending on a home help twice a week did surprise me - but there was no evidence there that she wasn't coping..."

The DN satisfied herself at this visit that the patient was managing a range of physical tasks that were essential to the maintenance of her wellbeing. Although focused on the procedure of Doppler assessment, the DN collected information to convince herself that there were no other salient issues that required to be dealt with at that time.

The problems faced by the DNs were often ill-structured and the context in which patient problems existed complicated the assessment process. Determining whether patients are managing or not was a strategy that allowed the DN to form an overall judgement of the situation. Within this process, delineating a main problem helped the DN to move the process forward. Long term care planning and paced interventions seem essential where patients have complex and hidden needs and problems have a range of potential solutions.

4.3.5 Summary - Making sense of the evidence in district nursing practice

The search for information at the first visit was an ongoing process responsive to the context in which the visit was taking place. Observation, which included using all the senses, was a significant source of information. What the DN was deducing from the surrounding environment influenced the search for information. There was acknowledgement that only so much information could be asked for at the first visit without it becoming an interrogation; observation, therefore, was an important source of evidence.

The agenda at the first meeting was predominantly nurse led and the DNs clearly had issues they wished to address at the first meeting. How the agenda unfolded was responsive to the information that the DN was able to glean throughout the visit. In this study, some of the patients visited were frail elderly people who seemed content to respond

to the questioning of the DN. Evidence of a proactive approach by the patients was limited even where opportunities were given. Indeed, if the DN had not led the agenda at some visits then long silences would have prevailed. At some visits, there was evidence of information being offered freely by the patient but this related to the personality of the patient and how quickly they seemed to relax with the DN. Visits were observed where the patient immediately started to pour out information to the DN. In these cases, the DNs worked with the patients and integrated their search for information around that being given by the patient. The information given by the patient tended to focus on areas which they thought the DN would be interested to hear about. Impressions from observing the visits suggested that at all visits the patients were satisfied with the outcomes of the visit, although it is acknowledged that patients and carers were not asked about this.

The case study (Chapter 6) illustrates an example of assessment practice. In this case the DN searched for the information she required and was particularly focused on the patient and his needs. However, the patient, George was a man of few words and sat back and allowed the DN to lead the visit.

The DNs were concerned with how patients were managing the day-to-day aspects of living and searched for evidence in relation to the most salient issues impacting on their lives. This was described as searching for the 'main thing'. The purpose of this search was to distinguish between, needs to be addressed there and then, and needs to be addressed in the future. This would suggest that the information search by the DN was influenced by the predicted outcomes of the visit; different goals required different information to inform decision making.

4.4 Category Four – Determining present and future care needs

The purpose of the first visit was to determine the present and future care needs of the patient and carer. The DNs were concerned with how the patients managed the range of activities essential to daily living. This included physical activities such as mobility, nutrition and the maintenance of personal hygiene. Additionally, how patients managed on a daily basis was linked to the social conditions and family dynamics that prevailed in the house.

Determining the present and future care needs of patients had 4 main elements:

- managing present care needs
- family care
- facing the unexpected
- keeping a foot in the door

4.4.1 Managing present care needs

Whilst the DNs acknowledged that assessment was an ongoing process and that it took time to build the bigger picture, they recognised that some aspects of care had to be identified, prioritised and dealt with immediately at the first meeting:

“We had a lady with a very bad burn last week and we immediately did her dressing because she was so uncomfortable and then thought about the admission later. I mean that was the criteria at that time was really to relieve her discomfort and to make the whole situation more comfortable for her” (DN 5:1).

This example highlights the reflexive nature of the first visit and the need to address the task; in this case rather than search for information. DN 5 viewed making the patient comfortable the priority.

DN 1 also highlighted the importance of responding to the situation encountered, by meeting the most pressing needs:

“Somebody might ask you to go and do a bathing assessment and when you get there, there could be a dramatic problem with incontinence or somebody is stuck in bed, doesn’t know how to get out and a carer is very stressed so bathing would really be the last thing they

would at that particular moment...want to talk about. It would be really how we were going to get this stressed carer to cope with a patient in their bed”.

Examples were given where the immediate care needs of the patient had to be prioritised. For example, DN 3 gave a detailed account of a visit to assess the patient for bathing. The reality of the situation proved to be more complex than the DN had anticipated and the stated reason for referral was not a significant problem for the patient (Section 4.4.3). Therefore, the DN had to deal with the immediate care needs of the patient.

DN 6 responded directly to a telephone call from the husband of a 72 year-old lady who said his wife had a ‘sore blistered bottom’. On examination, the patient’s skin was intact but she had an extensive skin rash over her sacral, rectal and pubic areas and down both legs. Prior to the visit, DN 6 had checked the patient’s medical notes and knew she had a long history of Crohn’s disease and had recently been in hospital for surgery for bowel resection. The DN told the patient she would ask the doctor to call to prescribe something for the skin rash. The DN discovered that the patient had a stoma and asked the patient several questions about how she was managing it and whether her ‘waterworks were OK’. The DN then explored with the patient how she managed to wash, assessed the suitability of the bathroom for bathing aids and told the patient she would ask an occupational therapist to visit. The DN said she would return again on Wednesday (this visit Monday). At this visit, DN 6 decided quickly that the doctor needed to call but explored a range of other issues relevant to the patient’s present care needs and identified that the patient needed some support following surgery.

4.4.2 Family care

When a person becomes ill, it is at home that many of the challenges and problems are met and it is generally the family that provides direct and ongoing care with the DN giving care only on an intermittent basis. The DNs talked about both families and carers and recognised that understanding family dynamics was important. However, where the patient’s needs were complex, the DN was likely to identify and work with one person as the main carer.

Interest in and concern for the person with the main care-giving responsibility, has increased since the 1980’s. Twigg et al (1990), argue that the term carer lacks clear analytic definition and centres on both the performance of tasks and social and familial

relationships. The term is a construct of professionals rather than of carers themselves and it is suggested that many carers do not recognise themselves as such and regard their actions as extensions of family or personal relationships.

The important role of the carer and the broader family was recognised by the DNs whether the patient was likely to require care over a long or short period of time. The presence or not of another family member was a significant cue and influenced the decision-making of the DN:

“...I knew the set up...I knew her husband was there...I didn’t have to ask ... ‘who is caring’ or anything, and she volunteered so much you know I didn’t have to say “do you get out to the shops” or anything. She was telling me” (DN 6:1).

DN 4 visited a lady following day surgery for a hernia repair. When asked what she was looking for at the visit DN 4 said:

DN4: 1 “...I wanted to see if there was help in the house and she of course had a very caring husband, so immediately a lot of your problems were solved for you”.

The presence of the husband and the young age of the patient and clinical signs reassured her that the patient was likely to recover well from her operation. DN 4 was asked why she had decided not to return and see this patient and she said:

“I am not going back to her at all for the simple reason...she obviously has someone in the house. The wound was very clean, no discharge from it. She’s got self-dissolving sutures so she’s not having sutures removed so I don’t see any problems with her at all. And that’s why I explained to her if she did have any problems with the wound to ring up, but she was young enough to understand you know what the problems could be. I don’t foresee any problems at all” (DN 4: 1).

Whilst there were other factors influencing the DN it is significant that she cited the presence of the carer first on both occasions when talking about this lady. DN 5 also thought that the presence of someone else in the home was an important determinant in her decision not to make a return visit to a young woman recovering from day surgery following hernia repair:

“I was quite pleased that she had people there looking after her... otherwise I might have been a bit worried. She did look pretty frail as though she needed a bit of help. That was the main thing” (DN 5:1).

The DNs were also reassured by the presence of paid carers/home helps as the following example illustrates:

“She came across, well the environment was quite good and it was safe and warm em... she had a home help which, who was there...her carer (home help) was there who she seemed to have a good relationship (with), who she spoke as having confidence in so that was good knowing she had that support and the carer was making her lunch for her...” (DN 2:1).

The DNs viewed the carers as resources and might assume that they would meet many of the care needs of the patient (Public General Acts 1990; Twigg et al. 1990; Twigg and Atkin 1994).

Where there were no family members living with the patient, DN 9 said this influenced her decisions and actions:

DN 9: 1 “I am influenced, quite influenced by whether they are living alone or not. I think if they are on their own and you have to...think a bit more carefully (than) perhaps if they have...someone in the house all the time...”

CK: “One of the other things you said was “if they live alone”...”

DN 9: 1 “Yeah I’d probably be visiting someone who lived on their own more frequently than somebody that had say very good family support or lived with a daughter because they have not got that back up. Subsequently, on subsequent visits perhaps visit them fairly frequently perhaps once a week or once a fortnight just to keep a sort of an eye on them. If...they are living with someone who is quite able - of course sometimes they might be living with someone who is just as frail so then you would still be visiting them fairly frequently. But if it’s someone that’s quite, fairly intelligent and you know that if anything drastic should happen that they will get on to the GP fairly quickly. Or you can tell them don’t hesitate to call us - I won’t be in till such and such a day but if there’s a problem before that please phone”.

The DN expressed clearly the potential impact of the patient living alone on her decision-making and actions. The absence of a carer meant that the DN could not assume that there was support for the patient. She identified the reliance that DNs place on family members to make contact with the GP or DN if needs arise. It was recognised that the carer might also be frail and in those circumstances decision-making about care would take this into account. Twigg and Atkin (1994) define this as the carer as ‘co-client’ where there is recognition that carers have needs in their own rights.

Where the patient had palliative care needs, the role of the family was vital even in the early stages of the illness. Terminally ill patients spend an average of 90% of their last year of life at home with the bulk of the care during this time provided by the family and informal carers (Doyle 1994). DN 5 described a recent visit where she acknowledged the role of the family:

DN5:2 "...I had a first visit yesterday with a terminal patient and the family were there and I mean it's early days yet - she is still going for radiotherapy...she is not ill yet. She is still very much in control of the situation but I think it's good that the family know that she has someone who is going to come in and just give her a bit of support...obviously the family for example at the moment will be responsible for the cooking, shopping that sort of thing and just generally keeping an eye on and he (husband) will probably call on other members of the family to give him a break".

Where the patient had more complex needs, it was recognised that the carer was likely to need help with problems. Whilst the DNs viewed the carers as resources and co-workers (Twigg and Atkin 1994), they also identified the need to support the carers as clients in their own right.

In response to the following question given to the DNs prior to the second interview, DN 1 gave a detailed reflection of a visit where limited referral information had been given and a complex situation unfolded when she visited.

CK: Question 6 *"Think back to a recent first visit, can you recall the referral information you were given and can you recall the decisions you made. Having completed the visit what were the key factors that influenced your decisions?"*

The DN described how she found the carer struggling to cope as the patient's condition had worsened. The needs of the carer were fundamental to her decision-making as the following example illustrates:

DN 1:2 "I had one last week...the man had psoriasis and his wife wanted some information about applying some of the creams, that sounded relatively straight forward. I have met this man before quite a while ago and I thought that sounds reasonable I'll go and see - he must have been given some new creams from dermatology and she had always looked after her husband. So I went to the house and he was in his bed about 10.30 which was unusual - he was normally up and she came into the bedroom with me and you know he had widespread psoriasis which I knew, and he talked about the appointment (at the hospital). Now they had had difficulty getting there, it appeared quite quickly to me that his mobility was poorer. It was unusual for him to be in bed so things were not as good.

He denied that he was unwell so he wasn't like in bed because he felt unwell necessarily but quite quickly I could sense that there was a lot of tension, a lot of stress there and they both actually started crying when I was talking to them about what had happened at dermatology and basically it had been a huge struggle for her to get him up, washed, dressed, in the car away up to (hospital) to go in and see what on earth they were going to do about the chronic situation and she was really at the end of her tether. Em, he was feeling terribly guilty because she was doing all this so we went through things like em you know when you are talking about the key factors, which influence your decisions. Well the main thing was that she was exhausted, she was very stressed. They had not identified before to me in any form that he was incontinent, they had been buying pads from Boots, they had struggled with that. Em and you know she was spending an hour per day trying to bath him, put the creams on and wash everything and change the bed. I mean the whole thing was just too much for her and she just felt totally exhausted ... So that visit ended up being quite a complex visit with lots of issues needing to be attended to and I will go back although he doesn't need nursing care at the moment she needs some support and he needs lots of things put in there to try and help them both and that was just a case of 'lets go and discuss the creams' ..."

CK "...that is a very complex situation you have outlined...what do you think was the major thing that influenced your decision-making...?"

DN1: 2 "Her, her - both of them crying and realising that they were just at the end of their tether and here was somebody that was relatively sympathetic and understanding being prepared to spend some time with them and said right lets have a chat about what we are doing here and that set them both off. She was stressed and he was crying because she was doing it all and you know I just felt that they needed some help".

This detailed account highlights the frequently reported situation by the DNs that often the reality of the visit did not match the referral information and it illustrates the prominence of the carer's needs. The patient needed assistance, but the recognition that the carer was not coping was the main cue used by the DN to determine her decisions and future actions. The DN saw this carer as a co-client (Twigg and Atkin 1994).

The presence or not of other family members acted as an important cue and clearly influenced the decision-making of the DNs. Where the needs of the patient were relatively straightforward either because the condition of the patient was temporary, for example, following surgery, or at the early stages of an illness where the patient was still independent, the DN assumed that if a family carer was present, the carer would undertake many of the activities vital to keeping the household going. This would absolve the patient from some responsibilities. Carers of patients with more complex needs were more likely to become co-clients where the DN recognised that they had different, but equally important, needs in their own right.

4.4.3 Facing the unexpected

The information from the referral gave the DNs a starting point, but there was almost an expectation that the real situation would be somewhat different to that anticipated. DN 3 gave a detailed reflective account of a recent situation where the outcome was completely different to that which she could have anticipated on the basis of the referral information:

DN 3:2 “Well this one - the first visit I was asked to do was Mrs ... ‘assess for bathing’. So that was the referral information - that was literally it. That might have been because I had been away for a few days so somebody else might have had a nice detailed telephone conversation - somebody from a ward. I don’t know but all I got was a wee sticky (piece of paper). Mrs so and so, address – ‘for bathing’. So I really had no information at all about that lady and sometimes I would go away and look at the person’s notes and sometimes I would just go in cold because that’s just the way it is. So I went off along there and I found this lady - she had a chronic chest condition - that I had no knowledge of - she was almost bed bound - if not house bound and really assessing for bathing really was not appropriate - partly because she had a beautiful appointed wet shower room that she could access with her mobility. Her problem was that the Social Work Department had given her a wee stool to perch on and she did not feel safe. So all I have done is ask for a shower chair and hopefully once she has that she will have competence and confidence with it. In the meantime, our auxiliary nurse is going to go in on a weekly basis to give her a hand to wash her back and her hair. But that’s a very small part of nursing intervention because through that we have explored an Attendance Allowance; we have explored portable oxygen; we have explored an electric wheelchair; we have explored the Chest, Heart and Stroke Association; we have explored her skincare needs so assessing for bathing really did not say an awful lot, so from that point of view - it was a very small word but it has lead to a big nursing input...”

CK: “So what was the most significant thing about that lady’s situation then that made you bring in all the help that you have outlined - do you think?”

DN 3:2 “Just a sense of helplessness - just a poor wee soul marooned in a bedroom with a beautiful shower that she could not access. You know and a wheelchair on loan from the Red Cross that she couldn’t use to get out the house because she did not have a ramp at the door. I just thought ‘that’s great there’s been a bit of input here’ but not very co-ordinated”.

Here, the DN identified very quickly that the patient had health problems with profound social implications that she would not have expected from the minimal information received prior to the visit. The DN decided quickly that her initial task – to assess for a bath - was inappropriate and set about gathering a range of information which led to a number of interventions to improve the patient’s quality of life.

The DN is likely to have more contact with the patient than any other member of the primary healthcare team (Badger et al. 1989) and is therefore the key professional for co-ordinating and introducing new services. This account demonstrates the role assumed by the DN in helping the patient to utilise equipment that had been supplied but with little regard for the user, and working with the patient to deal with other problems she was encountering due to her ill health.

Facing the unexpected could relate to procedural aspects of care as outlined by DN 11 who encountered an unusual dressing at a first visit:

“...it was a very poor referral which, as I say, we often have anyway but basically it was a very short note we had to go in and remove a pressure dressing - that was the only information we had. I did not check out any further. I just thought - I assumed - it would be a hernia repair or whatever because it came from ... (a local hospital) and I assumed that I knew what I was going into. Went in, totally unprepared - it wasn't a major thing but it turned out that it was a Kracker dressing and I had never seen a Kracker dressing in my life. I had no idea what I was going to (do)...I had a vague idea this might not be what I thought it was, so really I suppose going on that I should have checked it a bit more and in the end I wasted a lot of time - you know phoning round and finding out what was supposed to happen here” (DN11: 2).

DN 11 accepted responsibility that she should have sought further information, as she had a hunch that the visit could be problematic. Facing the unexpected, therefore could arise from the procedural/physical, social or contextual aspects of care.

4.4.4 Keeping a foot in the door

In some situations, the DNs identified no obvious needs for future intervention but indicated that under certain circumstances they would maintain contact and keep a foot in the door. This role differs from a proactive health promotion role, as the DNs did not actively seek out patients to prevent future health needs arising. Rather, they responded to situations where some health needs existed, albeit controlled at the present time, but where they anticipated that health needs would change to an extent that would require intervention from the DN service.

Nolan and his colleagues constructed a typology of family care to facilitate understanding of care that families provide (Nolan et al. 1995). Anticipatory care was one of seven modes of caring identified in this typology and was described as largely invisible care that involved the notion of doing something ‘just in case’. It is a sense of anticipation that

pervades a whole range of practical care. For example, in relation to the role of the family carer in pain management this might include alleviating the need for the patient to undertake activities that may induce pain (Kennedy et al. 1999).

Whilst there are parallels which can be drawn with the role of family carers in anticipating care needs, the DNs described a role where their anticipation of future needs was based on their understanding of the current health status of the patient. This was linked to the likely impact of this status on the patient's future health. Keeping a foot in the door was potentially beneficial for DNs and patients and:

“...a very big part of the District Nursing role...We might do a kind of informal pop in visit now and again just if we are in the area - how are things type of thing and find excuses really to go in if there is anything...it is important obviously so when the time (that more care is required) comes the relationship is already established - the communication lines are there and things are much easier to manage”

CK: “If you were to try and convince somebody that was a very legitimate part of the nursing role - how would you sum that up?”

“I think it's of great benefit to the patients obviously to know that someone is out there for support and back up and help if they need it, rather than you know you are trying to improvise - you are trying to prevent crisis management - you want things to fall into place naturally as they occur which is a much better way of delivering healthcare than managing a crisis really” (DN 11:2).

DN 6 was asked to visit a lady who was referred by her husband as she had a ‘sore blistered bottom’ (See Section 4.4.1). The DN thought prior to the visit that the patient had a pressure sore but in fact had an extensive skin rash which the DN decided very quickly into the visit had to be seen by the GP. In addition to assessing the patient's ability to meet her hygiene needs and referring the patient to the occupational therapist the DN said:

“...I have a feeling this lady may be on our books with different things...when I went I felt it was a pressure sore that I was going to look at...when her husband said she's got a blistered bottom...She may come on to us for various reasons I feel...seeing she has had recent surgery. And the stoma nurse I know is visiting but not terribly regularly...so I think she just needs a wee bit of support yet” (DN 6:1).

In some situations where the DN decided to give the patient ongoing care, anticipating other future care needs formed part of the decision-making process. DN 3 visited an 89-year-old gentleman to assess for bathing and was asked:

CK: "What do you think was the most significant thing in you offering him a continued service for bathing, you know, out of all the things that you have talked about so far?"

DN3:1: "Keeping a foot in the door I think, just making sure that if he deteriorates that we can help him, that we can get in there quick to help him. It might well be that he will improve cause it's very soon after his stroke and he has done very well in two months to be walking around almost independently".

As this theme arose from the first interview, the DNs were asked at the second interview for their opinion about this aspect of their role. They were clear that their workload dictated that they could not keep in touch with the patients just for the sake of it and they placed emphasis on creating a situation conducive to the patients contacting them should the need arise. However, there was acknowledgement that in certain circumstances it was essential to build up a relationship and keep contact with the patient in order to prepare for meeting future needs:

DN 5:2 "Whereas a terminal (patient) you are looking to build up a fairly long term relationship... You might not do any nursing for quite some time but I find if I get someone who is going to be terminal - even if we don't have them at home (to die) I make it quite clear from the first visit that I'll be attending them regularly - once a week or something like that and more if need be...just keeping an eye on them and just to give them support...usually it works out quite well".

Establishing a relationship and maintaining contact with patients who required palliative care was viewed as justifiable and the DN stated her reason for doing so:

DN 4:2 "...people who are referred to us early with a terminal disease or a serious illness in the future who you want to get to know and you want to build up (a relationship with). You visit them once a fortnight and it may start like that...because then you are supervising the change in their condition as the weeks and the months go by. That's different from supervising someone who doesn't seem to change from week to week".

Keeping a foot in the door where the DN anticipated future care needs emerged as an important insight to the role of the DN. The DNs used their understanding of the patient's current situation to determine whether there was an increased likelihood of future care requirements. Knowing when a monitoring role could be useful in identifying any change in health status to prevent unnecessary deterioration in the longer term was described. So too was the recognition that workload often prevented this from happening:

DN 8:2 "I mean we know there is potential problems there but what happens is they are ignored and there is a crisis and it's something if we had been monitoring, it wouldn't have been a crisis. Yes it would have been a problem, and you can pick out the ones for

example...wounds or on MS patients, people that you do know that there are going to be problems in the future and if you are just keeping your finger on the pulse as it were then you can respond...Some of them we can prevent, for example leg ulcers, once we get the leg ulcers healed and it's been shown that if you wear compression hosiery then the recurrence is much less but it is monitoring these people".

DN 8 differentiated between dealing with a problem as opposed to dealing with a crisis. Keeping a foot in the door in anticipation of future care needs was a legitimate part of district nursing practice based on knowing the underlying pathology and trajectory of certain conditions in association with the psychosocial and contextual aspects of patients' and carers' lives.

4.4.5 Summary – Determining present and future care needs in district nursing assessment visits

Determining current and future care needs in district nursing practice was an essential element of the first assessment visit. Whether the visiting pattern was likely to be one-off or sustained over a longer period of time, the DNs felt that they should anticipate future needs of the patient. Many of the scenarios described by the DNs were complex and multi-faceted. In the recognition that they could not impact on all potential care needs, the DNs actively sought to determine if there were tangible priorities, things they could help with at that time.

In many cases the DN faced a more complex situation than could have been anticipated from the information given at the time of referral. The DNs identified how they were able to cope with the unexpected at the first visit. There was a sense that they were confident in their skills and practice when dealing with a range of possible scenarios.

The relationship with family carers permeated the data, with the DNs normally viewing the carers as resources and co-workers in cases where the care needs of the patient were relatively straightforward. Often the anticipated role of carers was that of completing household tasks or providing some assistance with personal care where patients were recovering from surgery. In complex cases, the DN was more likely to identify the carer as a co-client who had as many or sometimes more needs than the patient. The presence or not of family carers was a major cue that informed the decision-making of the DN throughout.

The DNs described a role which went far beyond a task orientated approach to care. In some cases where the patient had no immediate needs for nursing intervention their understanding of the patient's physical, social and contextual situation encouraged the DN to maintain contact with the patient so that they could act quickly when health needs changed. This was particularly the case for patients requiring palliative care, where establishing a good relationship was viewed as pivotal to providing care and the DN could anticipate the probable illness trajectory. The rationale for this component of their role was to prevent a problem becoming a crisis.

4.5 Category Five - Working with constraints in district nursing practice

Three issues impinged on decision-making:

- acting as gatekeeper for services and resources
- changing priorities for patient care
- situations where little could be done and feelings of helplessness

4.5.1 DN as gatekeeper to services/resources

The refocusing of healthcare from hospital based care to primary healthcare (Public General Acts 1990) has influenced the role of the DN. The division of health and social services has altered the allocation and control of some community based resources and the DNs described the implications of such changes. They recognised that their role now included 'gatekeeping' the DN service.

DN 1 described the difficulties in determining whether her patient was eligible for bathing from the DN service and some of the options she could consider:

"...resources that I have, do influence what's happening. I suppose that influences whether I then go and refer her to an OT for a better piece of equipment that I can't get. For instance, she's got a bath board at the moment; now perhaps when I went next week a Manga seat would be quite a good thing to have and that would make her far more independent and that would prevent a nurse going in so you know I would have to think of what resources I have, what she really needs and try to find a balance there. And that isn't easy. I must admit, it is difficult...she could be regarded as almost a borderline case for taking on bathing in the sense that she says to me that she can wash herself at a sink and she has been doing that, how good that is I don't know at this as stage you know, but on the other hand she is incontinent and she does have a problem with that. So there we have something else to consider. So this lady is definitely incontinent, does have poor mobility, does have some degree of difficulty washing and dressing I would say and what I need to do is look at resources I have and the resources that...I can get a hold of...the resources I have as in staffing, and the resources I can get a hold of through either my own equipment or OT and what their need is but of course that is the first thing you would think about as well, what their need is and then work from there".

DN 1 had to weigh up the options and consider whether the patient's needs for nursing could be met through the resources available to her or by other services. She identified that having to balance the patient need with available resource was a changing trend:

"I think when I started this job 4 years ago...there was not so much thought about who was going to go in and bath this lady...we wouldn't be able to get equipment...and we didn't talk about money, now we're talking money. If this patient has an attendance allowance and they are borderline and really they aren't at risk of skin breakdown or whatever and they can wash at a sink then really I would be encouraging them to use their attendance allowance to get somebody in to help them. Now I wouldn't have thought of that 4 years ago. Whether that's, well then of course that's to do with the introduction of the Community Care Act, the resource is getting more limited, definitely it's made a difference".

CK: "Is it good or is it bad?"

"...I would see some of it as good in the sense that it maybe encourages us more to look at independence more closely and not create dependence. I know myself being in hospital it's always easier and quicker to do it yourself...to wash and dress the patient rather than let them do it themselves, the hardest thing is to stand and watch them, but in fact when they are at home they need to be independent because we are not going to be there that often. So they need to be as independent as possible, we need to encourage that" (DN 1:1).

Having more time to spend assessing patients was viewed positively. However, acting as gatekeeper to resources was viewed as a change to the DN role and coupled with increasing expectations of patients and carers some tensions were noted:

"...of course people, people in general are more informed about what's going on, what they can get a hold of and know "I can get a nurse come in now and bath me or provide equipment" or whatever.. I think the public are becoming more aware of what they can get" (DN 1:1).

The following quote was typical of a consensus amongst the DNs that the divide between health and social needs was unclear and it was necessary for the DNs to prioritise their own caseloads:

"You can quite often identify that they could be doing with someone to give them a hand ...with the bath - but the resource just isn't always there so again its just prioritising - are they incontinent? Have they got dementia? - You just have to prioritise that way. Em have they got somebody popping in that will make sure they are kept clean - it is quite difficult - we get a lot of bathing referrals and we can't take everybody on. We have a bathing auxiliary and she is already doing about 8 a day...We have an elderly couple just now who could really do with a hand but I know there is an 18 year old boy who'll be coming out of hospital soon with multiple sclerosis who will probably have to jump in front of them" (DN 9:1).

There was consensus that the DN role now included gatekeeping the service by prioritising patients whose needs should be met by the DN service. How the DN reached her decisions was individually determined and there was no clear-cut strategy for decision-making in

balancing patient needs against available resources. Whilst some patients needs were being met by social work carers, the DNs described a role where they often had to intervene where the tasks to be completed were beyond the untrained carer:

“I mean certainly we use Social Work a lot more, they put in a great deal of home care packages, I don’t know if that’s entirely good because the people they put in are certainly not trained. I mean they learn on the job; quite a lot of them would go in and offer advice but certainly the getting up and dressing mode or putting back to bed mode has certainly gone and we are there on a sort of a more an advisory level in a lot of cases or a supervisory level. We have quite a lot of patients who are completely under the care of a social work package apart from us perhaps looking in to look after their bladder or bowels or something and just check that everything is running smoothly. Em, it alarms me that people aren’t trained and that the people who put them into that situation, their supervisors aren’t trained and a lot of them aren’t trained in the nursing field either. I mean we have a lot of instances where we get beeped or phone calls or whatever from carers who have been asked to do jobs which are just beyond them” (DN 8:1).

Sharing care with the social work department was reported but, as this example illustrates, the DN service might become a fall back service for advice and intervention where the caring tasks were more complex. The responsibility felt by the DNs in trying to pull services together or meeting needs where gaps were evident was striking.

4.5.2 Changing priorities

Many of the traditional tasks carried out by the DN service, such as meeting the hygiene needs of patients have been taken over by home-care services organised by Social Work Departments. There was general agreement that the role had changed due both to policy changes and the increasing number of patients staying at home for care or returning home earlier from hospital care. Consequently, there was increased emphasis on chronic illness where complex nursing needs were likely to exist alongside acute episodes of illness, and more technical care.

The changing priorities in the DN role have implications for their current and future education and training needs. Educational needs were mainly met by in-service education and training programmes or at an individual level where the DN undertook personal study. The study participants undertook further education and training on an ad hoc basis and evidence of strategic planning by management to meet educational needs was limited.

Dedicating more time to paper work could lead to reduced time for patient care as identified by DN 8:

“...I think the pressure of work is high. The pressure now even more of paperwork if it's not documented...then you are really in serious trouble and the quality of the patients we are seeing... it takes a lot longer. For example, that assessment visit today, it took a long time and it will take a long time to document that and write it up and that's just one visit out of perhaps 12 or 13 I've got to do today. So you know if there's that woman at the end of the road crying, needing a good hour spent, I just sometimes don't have that. And the bereavement visits...these sort of things...they used to be part of our work. Supervisory visits used to be part of our work. You know, once somebody is better now that's them, they are chopped” (DN 8:1).

The changing priorities were generally viewed positively by the DNs who felt that their status and position had improved over recent years. The time freed up by the removal of more routine tasks was welcomed, as was the opportunity to expand their role. Greater expectations for the range of activities the DN might become involved in raised some anxieties about how they could meet their education and training needs on an ongoing basis.

4.5.3 Left feeling helpless

Throughout the interviews, the DNs demonstrated that although the first visit could be a difficult and different visit from subsequent visits, generally they felt well able to cope: however, certain circumstances left them ‘feeling helpless’. One such situation was coping with poverty and poor social circumstances:

“...social deprivation can be quite difficult to deal with, people who haven't got very much, haven't much finance, maybe have a drinking problem or smoke a lot all these kinds of things that we have to sort of (deal with). But you can generally help them a little bit but it is problematic. It makes life more difficult for them and for you. You know, just the basic comforts of life” (DN 5:1).

DN 3 gave an example where the social conditions of the patient were impacting on one of the main aims of her visit - to achieve wound healing. Balancing her personal and professional values and goals presented conflict:

“...I visit a lady just now, oh gee, her house you could stir it with a stick and you know what we put on her dressings is immaterial cause her social circumstance is such that ...really need to rub her out and draw her in again. Everything, I feel really quite at a loss there. I don't know how to get around this one you know. Like morally, how can I sort of

say to this person this will not do, it's the way the person lives. But professionally I know that if I want these wounds to heal x, y and z has to happen so it's very difficult to balance that so that puts me at a bit of a loss" (DN 3:1).

The needs of the family of a dying patient left DN 3 feeling helpless:

"...if somebody is in really dire straits at palliative or terminal stage of their disease and the family were really...I would feel very limited in what I could do and offering them tea and sympathy...what's that worth if somebody is breaking their heart?..." (DN 3:1).

The DNs were assured in their practice and rarely seemed to encounter situations where they could not help in some way. When they did, circumstances were clearly beyond their control.

4.5.4 Summary – Working within the constraints in district nursing practice

The DNs identified changes in their role which were a direct consequence of recent healthcare policy. The DNs needed to be conscious of available resources when considering how to meet the needs of patients. The DN might need to suggest to the patient that they use allowances to pay for care, particularly bathing, where the distinction between health and social needs remained unclear.

The increasing emphasis on the DN role in relation to more technical aspects of care in some instances raises important questions about the ongoing education and training needs of the DNs. There was a sense that the role was becoming even broader and that advanced technical skills and up-to-date knowledge and skills on aspects of care previously given in an institutional setting, such as ventilating patients, were now required.

The removal of some of the more routine aspects of the DN role - meeting the hygiene needs - was viewed as positive by all the DNs in the study, but examples were given where the DNs had to intervene when some aspects of care being provided by unqualified, but paid, social work carers were beyond their capabilities. There were inherent difficulties in separating out components of patient care as either health care or social care and the DN service seemed to be filling gaps as they occurred.

However, throughout, the DNs were confident in their approaches to first assessment visits. Circumstances that could not be remedied proved challenging and left them feeling helpless and dissatisfied with what they could achieve.

As a reflexive process, the DNs tried to respond to particular issues from the situation they encountered. The cues from the patient and the context in which the visit took place were central to the assessment process. Section 4.6 illuminates the process of assessment practice that has evolved from this study.

4.6 District nursing assessment in action – The process

The connection between knowledge (knowing that) and skill (knowing how) in the everyday assessment practices of DNs appears to be in the reflexive nature of the actions of the DN and the context in which the visit takes place. The process involves recognising issues, seeking information, interpreting the evidence collected, formulating ideas and making judgements to inform decisions about future actions.

This is a non-linear, non-sequential process (Figure 2) that responds to the issues that arise throughout the visit, and those that the DN identifies as relevant. Recognising salient features from the context is fundamental to the whole process and determines much of the assessment process. It is, however, difficult to discern the possible interplay between recognising salient issues and use of the senses and information gathering strategies.

Throughout the interviews, the DNs alluded to ‘experience’ as the mechanism by which they had learned. Some DNs identified in the second interview (approximately one year after the first) that they felt they had learned more since the first interview – learning was viewed as a continuous process that occurred in the everyday practice of undertaking first assessment visits. Learning was situational and contextual. Knowing how to respond in different situations involved the DN recognising similar issues and clusters of problems in differing contexts and exploring these in the current situation.

If learning about assessment is an active, continuous process that occurs in practice through recognising, seeking and interpreting information, formulating ideas and making connections and decisions, it raises important questions about how DN students learn to undertake assessment visits. The study participants were clear that whilst educational

courses and reading contributed to learning, the ‘knowing how’ of assessment practice evolved from the experience of ‘doing’ first assessment visits. The implications for the education of current and future DN students are discussed more fully in the concluding Chapter (Section 7.4).

Assessment in district nursing practice involved gathering information from the physical, social and contextual aspects of the patient’s and/or carer’s life in order to formulate judgements about how the patient and/or carer was managing all the activities essential to daily living. The purpose of this process was to inform decisions and subsequent actions in relation to current and future healthcare needs.

Five main stages form the basis of DN assessment practice. These stages are non-linear and the process is dynamic. It involves responding to the cues present in the situation and is influenced by the knowledge base of the DN and available resources (Figure 2, Pg. 157).

1. Recognising salient issues from the context

The DN has to interpret what is going on and what ‘stands out’ in the situation. This involves selective recognition of the salient issues. In the process of selecting salient issues the DN may discard certain information quite quickly if no problems are identified.

Salient issues may relate to the environment, the physical and psychological condition of the patient and the role of other family members.

- The environment – is the home environment safe and suitable for daily living?
- The physical and psychological condition of the patient – what features of the patient’s functional capacity and abilities are impacting on their daily life?
- The role of carers – is the DN reassured by the presence of a carer and their expected and/or negotiated contribution to the patient’s care?

2. Seeking information by use of senses and asking questions to confirm/disconfirm the need for intervention

A significant amount of the information collected at the first visit is through observation. This may start as soon as the DN leaves her car and is approaching the home of the patient or at the front door. Observation helps the DN to 'pace' her search for information and avoid the visit turning into an interrogation.

Collecting information by questioning is responsive to the context observed by the DN. The questions asked change in keeping with the situation and fluctuate between the functional, social and psychological elements of assessment and care. The data demonstrate that the DNs often started with the functional aspects of assessment and moved on to the social and psychological elements of care. This progression seems logical and was linked to the relationship elements of the first visit, where it would be inappropriate to ask for personal information immediately upon meeting the patient and/or carer.

Some boundaries surround the depth, volume and nature of information that can be collected at the first visit. The DNs recognised that a relationship had to be established before some personal information could be requested.

3. Interpreting information and formulating ideas on the basis of the evidence collected

The DN formulates ideas about whether there are issues that merit further investigation/intervention and those issues that appear not to be problematic. Again, this formulation of ideas may start at the point of referral and before the DN has even met the patient, as she approaches the house, or on the first impact of the meeting. Expectations that the DNs had in some cases, prior to the visit, were not always borne out.

4. Making connections and comparisons between the evidence collected and the context and forming a judgement of the situation

The DN considers potential options and tries to make a judgement that involves weighing up or estimating the possibilities that certain things will/will not happen within the overall situation. This judgement is temporal and pertains to the situation existing at that time.

The DNs may have to identify and resolve tensions about how much information can be collected at the first visit. Trying to establish what the main problems were could be difficult if there was insufficient information available to determine the bigger picture.

5. Deciding to act or not to act

Decision-making will not always result in an action but may involve a judgement that the situation is satisfactory, the patient and carer are ‘managing’.

The assessment process in DN practice involves:

- **needing to know** certain information about the patient, their current situation and context,
- **acquiring** information
- identifying areas that the DN **needs to know more about**
- knowing what **needs to be done now** and what can be **left for the future**

The assessment process pivots around the task with an identifiable relationship between the task and the information required on which to base the assessment. Where the task is relatively straightforward, for example a wound dressing following day surgery, the DN seems to look for evidence to confirm that there are no additional needs or issues arising. The DN appears to make an almost immediate decision without generating a range of options. This deductive approach to reasoning involves deciding that everything is all right, that the patient is managing and collecting specific information to make a general assessment of the situation and support the hypothesis. This approach to decision making reflects descriptions of intuitive decision making as a rapid, effortless process which can be validated as it:

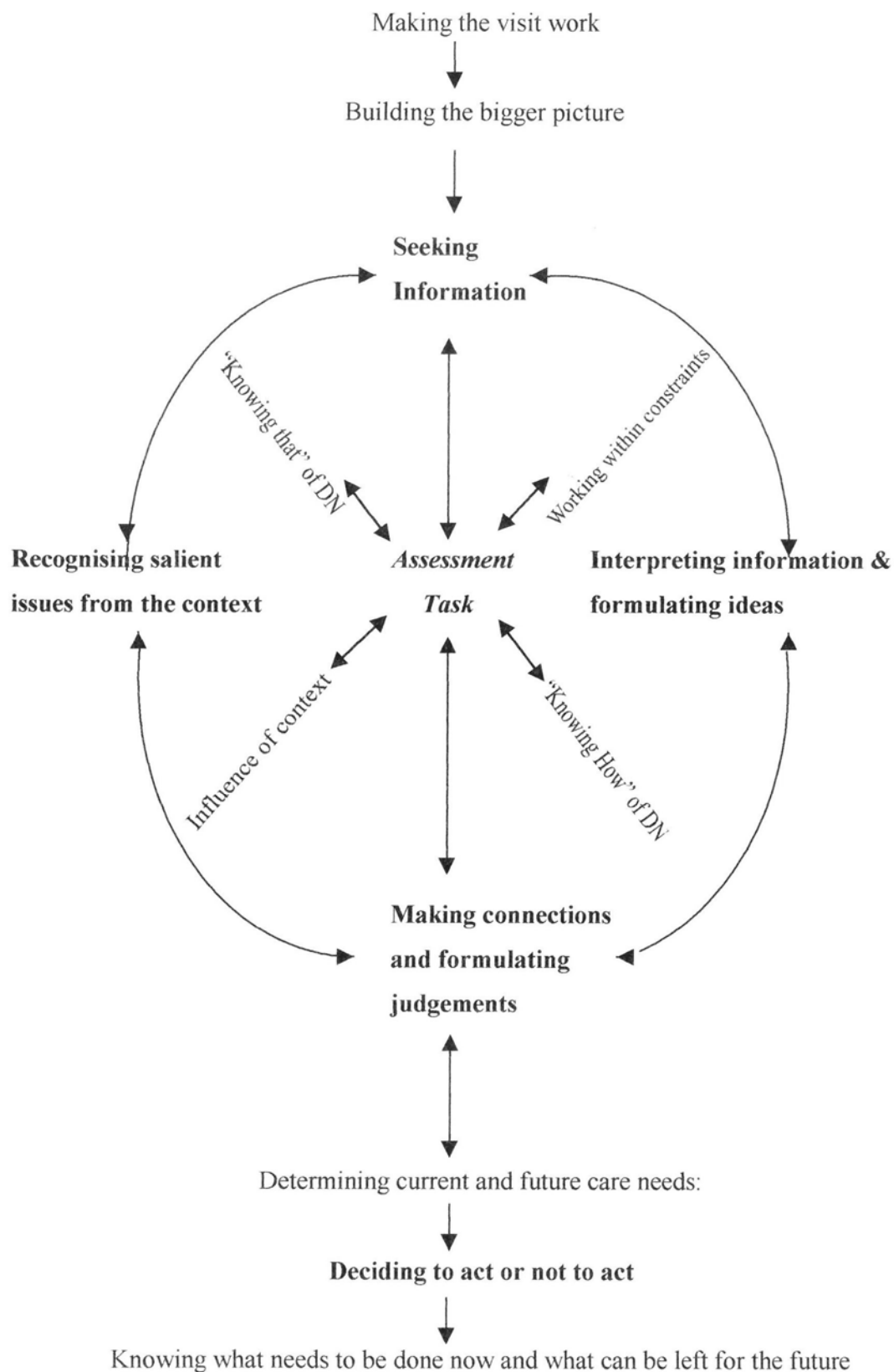
“...involves the use of a sound, rational, relevant knowledge base in situations that, through experience are so familiar the person has learned how to recognise and act on appropriate patterns” (Easen and Wilcockson 1996 Pg. 672).

Where the task is less structured, for example general assessment or a chronic wound, the DN looks for evidence more widely. General information is collected to help identify the specific needs of the patient and involves an inductive approach to reasoning. Further evidence is then sought to confirm the need for interventions. In complex practice situations, the DNs moved between inductive and deductive clinical reasoning processes. This is discussed further and illuminated in the case study (Chapter 6).

Both approaches helped to build the ‘bigger picture’ to make decisions about future care. How complete the picture needed to be (and could be) varied with the complexity of the situation. Many of the problems encountered by the DNs were complex and all the information required might not be available at the first visit. Consequently, clear cut decision making applied in relatively straightforward situations. In more complex situations, where there was recognition that the situation was likely to change, preliminary temporal evaluation only was made and decision-making was less clear cut.

The insights gained into the assessment process have illuminated the temporal and individual nature of first assessment in DN practice. Chapter 5 focuses on the exploration of the knowledge base of the DNs and the connection to their decision-making strategies.

Figure 2: MODEL OF DISTRICT NURSE ASSESSMENT



CHAPTER FIVE: KNOWLEDGE & DECISION MAKING IN DISTRICT NURSING

5.0. Introduction

One of the original aims of this study was to identify and categorise the knowledge used by DNs undertaking first assessment visits (Chapter 3, Section 3.1). This aim was influenced by the initial search of the literature which explored the seminal work of Carper (1978). Carper's work (Chapter 2, Section 2.3) was significant as it named knowledge forms in addition to empirical, scientific based knowledge and set out four patterns of knowing in nursing: scientific, aesthetic, personal and moral knowledge.

As the exploration of the literature progressed, it emerged that nursing literature regarding the nature of nursing knowledge was essentially discursive or theoretical in nature and with the exception of a few studies, lacked an empirical base. The literature review also identified the increasing attempts by nursing scholars to legitimise the knowledge embedded in clinical practice and the inherent difficulties in trying to do so (Benner 1984; Mackenzie 1992; Meerabeau 1995; Macleod 1996; McIntosh 1996).

In particular, the work of Luker and Kenrick (1992) and MacLeod (1996) (Chapter 2, Section 2.3) raised important questions for the researcher in relation to the purpose and feasibility of trying to classify the knowledge used by DNs undertaking assessment visits. These writers suggested that untangling the different elements of knowledge could pose insuperable difficulties or be possible only for some elements of practice. This problem was confirmed in preliminary data analysis. For example, at the observed visit where DN 8 carried out Doppler assessment to determine the appropriate treatment for a patient's venous ulcers (Pg. 108), the DN was able to articulate aspects of the knowledge underpinning the procedure and demonstrated competence in the task of carrying out the Doppler assessment. Whilst these elements of knowledge could be untangled and explained by the DN she also used a range of interpersonal and other assessment skills. She knew how to explain the procedure to the patient and how to select those aspects of the patient's situation to include in her assessment. In other words, the DN knew that certain factors such as age, diet, level of nourishment, ability to cook, ability to keep bandages in place, to stay warm and her social circumstances were relevant to the particular task of treating the leg ulcer. These elements of knowledge were difficult to untangle by either the DN herself or the researcher.

Carper (1978) argued that the four patterns of knowing identified were all equally necessary, interrelated and interdependent. However, if those working with the framework do not fully explore the inter-relationships between patterns:

“The framework, then, becomes a convenient grouping of categories for organising discrete components. For example, all science belongs in the empirics: nursing art fits with aesthetics: and ethics is decision-making about the right or wrong nature of nursing actions. Personal knowledge becomes the ‘catch all’ for thoughts or perceptions originating with self. When this happens the complexities of knowing are reduced to the obvious or the absurd” (Smith 1992 Pg. 2).

Smith (1992) argues that knowing in nursing practice is a holistic and integrated process that may have multiple dimensions or sources including nursing science, other sciences, arts, humanities or life experiences. She uses the analogy of the weaver to illustrate how individuals create a unique process or product:

“Our sources of knowledge may be both similar and different, and the threads we select from those sources are personal choices. The patterns and hues of each fabric are distinctive. In this way all knowing is fundamentally and primarily personal knowing” (Smith 1992 Pg. 2).

The researcher and three supervisors independently examined sections of data where the eleven DNs described their decision-making in the first interview. The purpose of this process was to examine the ‘fit’ between the study data using the scientific, experiential and personal dimensions of knowledge identified from the initial review of the literature as an analytical framework. Four main issues resulted from this exercise:

- Different knowledge patterns could not be meaningfully distinguished
- The context in which knowing takes place was relevant and should be acknowledged
- The reciprocity in the nurse/patient relationship was relevant and should be acknowledged
- Knowing what might happen in the future was fundamental to the assessment process.

The researcher and three supervisors could not discern clearly from the accounts, Carper’s discrete elements of knowledge utilised by the DNs and the subsequent impact on their decision-making and actions. In the few instances where they could discern different elements of knowledge, there was little consistency between the interpretations. The constant interplay between the ‘knowing that’ (theoretical knowledge) and the ‘knowing

how' (practical knowledge) of the DN precluded identification of knowledge as that derived from different sources. As Smith (1992) suggests, personal knowing was indeed the 'catch all' for the knowledge embedded within the data.

This is not to suggest that knowledge was absent from the practice of the DNs but rather that knowledge was demonstrated by the intentions and actions of the DNs within a specific context. It was agreed that an attempt to interpret and compartmentalise knowledge in this manner was impossible and would have resulted in meaningless interpretations for DN practice. This led to a revision of the first aim of the study. The description of the 'knowing in use/action' (the amalgam of 'knowing that' or theoretical knowledge and 'knowing how' or practical knowledge) demonstrated by the DNs in assessment practice was judged to be a more realistic and achievable aim. For example, this shift might involve identifying that the nurse understood the physical and psychosocial impact of a patient's incontinence on his life rather than demonstrating the physiology of the urinary tract.

Uncovering hitherto covert patterns of behaviour and rationales for decision-making in DN practice required an approach that would facilitate understanding of the synthesis of the 'knowing that' and 'knowing how' demonstrated in the everyday practices of the DNs. Synthesis, which seeks to achieve a rich description of actual nursing practice, is in keeping with the interpretative approach (Benner 1984; Lincoln and Guba 1985).

Describing knowledge in action in district nursing practice by the construction of a typology of district nursing knowledge was judged to be a useful way forward. It is acknowledged that the interpretation of 'knowing in action' is difficult given that such knowledge may contain several elements. Additionally, interpreting knowing in action involves the researcher/observer in drawing inferences, which may present a challenge to the validity of the findings. In addition to the data used to construct Chapters 4, 5 and 6, the measures adopted to ensure the truth-value of the interpretation are described in Chapter 3, Section 3.15 and Chapter 7, Section 7.2.7.

The themes and categories described in Chapter 4 sought to provide an in-depth description of first assessment visits in district nursing practice. The model illuminating the process of district nurse assessment (Figure 2 Pg. 157) was distilled from this description in order to demonstrate the reflexivity of the assessment process. The purpose of the

typology now presented is to move this description towards an explanation that can account for the knowledge used by DNs in their practice of assessing patients (Hammersley and Atkinson 1995).

5.1. Knowledge in action

The construction of a typology requires the researcher to assume an interpretative approach where the inherent meanings are understood without removing these meanings from their context. Data drawn from the field notes and the two interviews were assembled for each DN. The data were interpreted using the constant comparative method of data analysis already described in Chapter 3 (Hammersley and Atkinson 1995). The purpose of this approach was to identify meanings and content rather than theoretical terms.

Six categories of knowledge in action were distilled from this process and the description that follows is based on the patient visited by DN 11:

Biomedical knowledge in action

- Understanding the physical condition
- Detecting other physical problems
- Anticipating deterioration or improvement in physical condition

Psychosocial knowledge in action

- Understanding the psychological impact of the condition on patient and carer
- Knowing about the social set up of the patient and/or carer
- Assessing the suitability of the physical environment
- Determining support systems
- Understanding family dynamics

Demonstrating/explaining knowledge in action

- Giving information about future treatment
- Giving advice/instruction

- Practical demonstration

Communication skills knowledge in action

- Knowing how to actively observe
- Knowing how to actively listen
- Knowing how to seek and give information
- Knowing how to recognise and interpret cues

Procedural knowledge in action

- Knowing how to carry out a range of practical skills
- Knowing how to demonstrate respect for patient and carers through actions

Resource/community knowledge in action

- Knowing what DN resources were available
- Knowing what equipment was available
- Knowing what other services to refer to

Biomedical knowledge in action involved understanding the physical impact of the condition (reason for referral) on the patient and also how broader aspects of the biological functioning of the patient such as vision, hearing, sleep patterns, nutrition and elimination processes were impacting on the patient's life. Knowing about the condition related to the physiology, the treatment possibilities and the possible illness trajectory. For example, in relation to wound healing, the DN had to understand the physiology of wound healing to assess whether the wound was healing satisfactorily. DN 11 explained her decision not to re-visit a patient who had undergone a hernia repair the previous day:

"...If the wound had not looked so clean and sort of healing well at this stage then we would have gone back. If there had been any leakage on his dressing, anything like that we would probably have gone back in a couple of days or the beginning of the week but quite often if it looks that way at the moment then we don't. We advise them to leave it exposed" (DN 11: 1).

DN 11 assessed that the wound was infection free and healing satisfactorily, and she anticipated that it was likely to continue to heal without complications. She also looked for other physical problems and asked the patient about pain, sleep patterns and elimination processes as aspects of his condition that would contribute to the recovery process.

Throughout the study, the search for information by the DNs to determine the impact of the **psychosocial** conditions on the patient's abilities to cope with daily living was striking. Understanding the impact of the condition on the psychological state and the social activities of the patient and carer was vital to this process. The DN noted the state of the patient's home and the support that was necessary to maintain the physical and psychosocial wellbeing of the patient and carer.

DN 11 was satisfied that her patient was living in circumstances conducive to promoting recovery without complications. The family support available and the prevailing social conditions formed part of this judgement:

"...I mean I can't anticipate too many problems. The only problem I would maybe expect there would be a complication with the wound, not that I would expect it but I wouldn't be surprised because post-op that sort of thing can happen, but with the house and family support...he's young, he's fit. I would not anticipate too many problems there"

CK: "...you said to the patient that you would not go back, can you tell me why you decided on that?"

"...I would say experience, because experience has shown us that we don't necessarily need to go back for a wound which at the moment looks uncomplicated. And there are no other reasons for going back, social reasons or whatever" (DN 11:1).

This example illustrates the integration of biomedical knowledge with psychosocial knowledge as the DN formed her judgements of the situation. Knowing that a wound needs certain conditions to promote optimum healing was linked to social conditions. There was a clear relationship between biomedical knowledge and psychosocial knowledge in action.

Recognition that the DN was only present in the home of the patient for short periods influenced the **demonstrating and explaining** role of the DN in helping the patient and carer cope in her absence. Information about future treatment formed an important part of this category. For example, DN 11 told her patient when his suture should be removed. She also imparted information about potential complications that could occur with his wound

and advice about when and how to contact the DN service for help. Practical demonstration and advice about tasks such as applying dressings after bathing was important as the DN did not plan to make a return visit. Giving information to promote compliance with treatment was also vital and DN 11 advised her patient to take medication for pain at regular intervals. She linked to this, advice about taking measures to avoid constipation which she explained was a potential side effect of the medication prescribed for pain. Demonstrating and explaining knowledge in action was also therefore linked to bio-medical knowledge in action.

The range of **communication** skills displayed by the DNs formed the crux of the assessment process. Capturing the 'know how' of the DNs who displayed appropriate and confident approaches to visiting patients and carers at home is particularly challenging in a written format. Chapter 4 offered a description of how the DNs approached 'making the visit work' (Section 4.2).

Communication is context bound and an interaction that takes place in a person – situation context (Dickson 1995). The four main purposes of communication have been defined as to inquire, to inform, to persuade and to entertain. In each of these activities the interaction between the content value of the message with the perceptual value of the message is expressed in the verbal and non-verbal behaviours of the participant (Leddy and Mae-Pepper 1993). In the nurse/patient interaction, giving reassurance to patients and carers would also seem to be a vital component of communication. Each of the first three functions of communication outlined above and the process of reassuring patients and families could be discerned from the observational and textual data. Whilst the DNs did not set out to 'entertain' their patients as such, the use of friendly approaches to facilitate their search for information and in establishing a relationship was essential to the DN/patient communication processes.

Observation of DN 11 during the visit confirmed that she enquired about a range of issues relevant to the condition of the patient. DN 11 enquired about a range of physical psychosocial issues such as pain, sleep patterns and family support. She also informed the patient about his expected progress and advised the patient to take medication, to relieve pain, on a regular basis.

The importance of non-verbal communication was fundamental to providing the DN with important information about the patient, carer and their environment. DN 11 was reassured that the home conditions of the patient were satisfactory. Additionally, the verbal and non-verbal messages exchanged between the DN and the patient and carer formed the basis of the relationship. DN 11 approached this visit in a tactful manner. The patient was relaxed and jovial throughout the visit. Although the DN collected and imparted a significant amount of information, the pace of the visit was appropriate and DN 11 responded to the verbal cues given by the patient. Prior to the visit the DN stated that she thought the visit would be straightforward and this was so. By the time the DN left, the patient and his wife, who was present throughout the visit, knew what complications to look out for, when the suture was to be removed and how to seek assistance should complications arise.

Knowing how to approach a patient for the first time and conduct an assessment in the home of the patient with tact and sensitivity combined with skills of negotiating how to meet patient and carers needs was largely attributed by all the DNs in this study to experience.

The DNs were observed undertaking a range of **procedures** such as dressing wounds, helping people to bath and wash and more specialised procedures such as Doppler Assessment. DN 11 dressed the wound of her patient while seeking and giving information. The connection between what the DN was seeing, asking and doing was evident and part of the reflexivity of the assessment process.

Knowledge of local **resources** was particularly relevant and essential for the DN and the influence on decision-making clear. DN 11 knew that her patient could attend the treatment room to have his suture removed thus removing the requirement for a further visit from the DN service. She informed the patient that she would make an appointment for him on her return to the surgery.

Knowing about local resources related to those provided by the DN service, the other members of the healthcare team and other agencies including social work. Knowledge of resources included equipment in the form of mechanical aids, for example, bath aids, and allowances such as the Attendance Allowance in addition to the services of other healthcare professionals.

The knowledge in action identified from the data could be classified under the categories outlined above. However, the constant interplay between the knowing that (theoretical knowledge) and the knowing how (practical knowledge) of the DN coupled with the influence of the context in which the first visit took place could remain uncovered without synthesis of these categories to a meaningful whole.

5.2. A typology of knowledge for district nursing practice

The data provided empirical support for six dimensions of knowing in district nursing practice. Each dimension combines 'ways of knowing' into coherent wholes to facilitate understanding.

The dimensions are:

Getting to know the patients in their own setting

Getting to know the carers

Knowing what needs to be done now

Knowing what might happen in the future

Knowing/recognising knowledge deficits

Knowing the community resources and services

5.2.1. Getting to know the patients in their own setting

'Knowing the patient' is a recurring theme in recent literature (Jenny and Logan 1992; Radwin 1995; Benner et al. 1996) and throughout the data the DNs made reference to 'getting to know' or 'knowing the patient'. This pertained to their understanding of the patient and the patient's situation and related to the DNs decisions to undertake particular actions. This type of knowing differs from formalised decontextualised knowledge such as that involved in knowing the stages of wound healing, and emphasises the importance of practice based knowledge or know how in everyday clinical practice (Tanner et al. 1993).

Liaschenko (1997) argues that knowing the person implies an in-depth knowledge of the individual which includes knowing about their history and how individuals live their particular lives. Clearly, knowing the person as described by Liaschenko (1997) is not possible at the first visit. Even where the nurse/patient relationship extends over a period of

time it may not be possible or necessarily desirable, due to patient choice in relation to the information shared with the nurse, to achieve this depth of knowing. Throughout, the DNs in this study emphasised their efforts to reduce the potential intrusion that patients may experience at the first visit. Knowing the person, as defined by Liaschenko may involve enquiry about aspects of the patients' lives that have no apparent or direct bearing on their current situation.

Tanner et al (1993) identified two core components of knowing the patient – *knowing the patient's pattern of responses to particular clinical episodes* and *knowing the patient as a person*. Knowing the patient's pattern of responses to particular clinical episodes included knowledge of the case. Knowing the patient as a person involved the nurse in taking an involved attached stance to aspects of the patient's life which were salient within the context of nursing.

The core components identified by Tanner et al (1993) resonate more directly with the current study, given the inherent difficulties and possible limitations in uncovering scientific and experiential knowledge as discrete entities. Additionally, the first visit as a getting-to-know experience takes place in the home of the patient where aspects of the patient's life are visible and tangible. This facilitates the acquisition of knowledge that gives insight to the patient as a person and how they operate within their own environment.

Current literature (Tanner et al. 1993; Radwin 1995) on knowing the patient implies that in order to do so, the nurse must first understand the case and then, second, the resulting impact on and responses of the patient to their current clinical condition. In the current study the converse was revealed. In complex situations, understanding the impact of the illness and the patient's patterns of responses to their current clinical condition was viewed as a primary aim of the first visit.

Getting to know Jean in her own setting

DN 9 was asked to call on Jean, a 73-year-old lady who attended the local lunch club. The referral had come from the Social Work Department who thought that Jean might have a problem with incontinence, as other members of the club were complaining that she smelled of urine. DN 9 was asked to assess Jean who was surprised to see the DN and obviously was not expecting her to visit. Jean was neatly dressed and after initial hesitation

at the door invited the DN and researcher into her living room. The living room was dull but warm and tidy. Jean did not think that she had a problem with her ‘waterworks’ when asked by the DN on several occasions throughout the visit. At interview, the DN was asked why she had not told the patient the reason for her visit. DN 9 responded:

“...she had good family support. She didn’t really think she had a problem, she seemed perfectly happy...she wasn’t offensive, smelling offensively and the house seemed clean...she did seem clean. She is living with her grandson so she is not alone...it really seemed to be more of a problem to other people rather than to her and I really felt she was quite happy and I really did not want to give her anything to worry about” (DN 9:1).

In order to get to know the patient as a person DN 9 required to take an initial and almost immediate grasp of the patient’s response to her current situation. She did not conduct an in-depth systematic assessment of Jean’s continence status at that moment but rather decided that she would get more information from the social worker about why the referral had been made. The realisation that being labelled as incontinent and the fact that the patient would have been aware that others had complained about her, stopped the DN pursuing specific information about Jean’s continence status. The DN drew on the salient issues arising from the situation and decided that there was no evidence at that moment to support the assertion that the patient was incontinent. The actions of the DN in not challenging the patient demonstrate the values-based knowledge of this DN who respected the patient as a person and her feelings.

Knowing the patients’ patterns of responses to particular clinical episodes was discernible in the accounts of the DNs. In this broad category several issues relating to the knowledge of the DN could be identified:

- ***Understanding physiological and psychological responses to illness*** – understanding how the patient was coping with a temporary/chronic/terminal condition
- ***Recognising responses to therapeutic interventions*** – knowing what treatments to recommend where appropriate and knowing if the patient was responding appropriately to interventions such as medications and wound dressings
- ***Being able to assess physical capacities*** – assessing the abilities of the patient to self care in the physical aspects of living such as mobilising and meeting personal hygiene needs
- ***Establishing routines and habits*** – assessing the routines and habits of the patient and detecting any changes e.g. sleep patterns, strategies for getting in and out of the bath.

In Chapter 4, the importance of making the visit work was described. The endeavours of the DN in relation to giving the right impression at the first meeting and establishing mutual trust and rapport were the mechanisms through which getting to know the patient became possible.

Getting to know the patient emerged from the Phase 1 data and the DNs were asked at the second interview what this meant to them. The DNs identified a range of areas that they would want to know about including knowledge of the patient's family, the support available to the patient, the social activities of the patient and some information about their past medical history. There was considerable emphasis on those aspects of the patient's life that would give the DN information to help her understand the patient in their own context.

CK: "Getting to know patients in their own home seems to be important for District Nurses. What sort of things do you need to know to achieve that - getting to know somebody?"

"Well I think you need to know a bit about their past medical history because that can tell you a lot about somebody - what difficulties they have been through... what kind of family support they have if any. I think because it gives you an insight into what is going on, because quickly you can tell what difficulties (they have) and that can be adding to the picture. I quite often ask people about their families if they have pictures in their houses and things - you can pick up so much about what has happened to somebody and that can often help your judgement about how you might think they will cope" (DN 10:2).

Asking about family photographs was a deliberate strategy to help DN 10 get to know her patients. Collecting information from the family and social set-up of the patient was identified by a number of the DNs:

"I think (you need to know the) level of support they have - family support, if it's not coming from family - what sort of support they have - their social activities - do they get out. A bit about their background, what they used to do, what were their interests or what are their interests" (DN 8:2).

"Certainly... if you know they have a family and you ask them about the family, especially an elderly person, you know they might have children and grandchildren and great grandchildren, (they can) reel all their names and all the rest of it. You know I like to know... what sort of work they might have done or what they do or whatever and that sort of thing" (DN 10:2).

Getting to know the patient in their own setting was influenced in part by the values of the DN and what she thought was important to find out about the patient as a person. DN 1

was aware that it was easy to jump to conclusions and thought the communication skills of the DN were fundamental to the process of getting to know the patient:

CK: "As a District Nurse, what kind of knowledge do you think you need to have in order to do the things that you have outlined?"

"I think apart from knowledge you have to have a genuine interest in what people feel and think. I think you have to be able to listen very carefully to people. I think a lot of us don't listen properly. We make assumptions quite quickly and judgements quickly and put that on to the patients but we don't actually speak to them - how do they really feel about everything. I think that's a skill as opposed to knowledge. I think it's a very difficult thing to teach people - having seen a lot of students I think it's an incredibly difficult thing to teach. Knowledge, well - I mean knowledge of disease processes obviously it would help you through that. Knowledge about communication skills I suppose - I still think it's a terribly difficult thing to teach communication. I think you are either good at communication or you are not. I do honestly believe that - that may be naive of me but I look at some people who have been through the same course as me and I think it's a lack of kind of a general interest in how people really feel. Maybe that sounds terrible but sometimes I feel that. You can have all the knowledge you want about disease processes but if you can't communicate with the patient and really find out I don't think you can do it well... You can see that quite clearly with doctors who are highly qualified in all sorts of things and some of them cannot communicate with patients" (DN 1:2).

Theoretical knowledge of disease processes alone was not enough to inform the 'knowing how' of assessment practice. The emphasis on a knowledge base derived from social rather than biological sciences and the importance of communication skills was striking. When asked what knowledge and skills she thought she had to help her get to know the patient, DN 4 said:

"Well, I think I am a good communicator and I think I can talk to people very easily - I don't find that hard. I am never embarrassed or shy about going into someone's house. So I think the communication with the patient is probably the most...really important because as I said before some of them are very concerned or worried about you going... It's something quite big in their lives...a friendly easy attitude to people because the last thing you want to do is to frighten them - if you frighten them on the first visit I think you will have a big problem later on and nurses sometimes can be formidable if they want to be" (DN 4:2).

In summary, getting to know the patients in their own setting was a significant pattern of knowing in district nursing practice. It involved knowing how the patient was responding to their illness and also getting to know about those other aspects of the patient's life that they chose to share. The findings of this study resonate with some attributes of getting to know patients as identified in current literature, although there are some important differences (Jenny and Logan 1992; Tanner et al. 1993; Liaschenko 1997). Rather than

finding out about the patient's responses to a particular clinical situation as a precursor to getting to know the patient as a person, the DNs set about finding out about the person and their lives to facilitate the process of assessing how they were coping with their clinical condition. The strategies adopted to make the visit work were the processes by which getting to know the patient became possible.

Getting to know the patient is central to district nursing assessment and clinical judgement. It represents knowledge in action and extends beyond the assessment of physical attributes. Getting to know the patient is a combination of theoretical and practical knowledge that integrates the processes of seeing, asking and doing and allows the DN to intervene in the salient aspects of the patient's life.

5.2.2. Getting to know the carer

A range of literature emphasises the growing recognition of the role and contribution of family carers to the care of patients in the community setting (Nolan and Grant 1989; Public General Acts 1990; Doyle 1994; Twigg and Atkin 1994). When a person becomes ill, it is at home that many of the challenges and problems are met. Whilst the primary healthcare team have a responsibility to anticipate needs and address these, it is generally the family or other carers who bear the brunt of the direct caring. The district nurse may only be present in the home for short periods of time so she needs to assess who is available to care for the patient. For example, terminally ill patients spend an average of 90% of their last year of life at home with the bulk of the care during the final year of life provided by the family and informal carers (Neale 1993). Getting to know the carer/family support network and understanding and dealing with the strain illness can place on a family was therefore a significant area of knowing in district nursing practice.

Twigg and Atkin (1994) make a useful contribution to understanding how health and social services perceive and meet the needs of carers:

Carers as resources; this model regards the cared-for person as the main focus and the carer as secondary. It reinforces the reality that social care is delivered in the main by informal carers

Carers as co-workers; this model recognises that professionals and carers work together as partners in caring and emphasises the importance of maintaining the morale and good health of the carer

Carers as co-clients; in this model, carers are regarded as the focus of professional help in their own right. Services are arranged to support the carer and their abilities to cope

Superseded carers; this model is quite different, as the main aim of support is to free the patient from dependence on the carer (or vice versa). The focus of the intervention might be on encouraging the carer to promote independence for the cared-for person.

The first three models of service could be discerned from the current study. As the superseded carers model focuses on achieving independence, this would normally be a long-term goal and as the current study was focussed on the first visit, it was unlikely that this model would emerge. Examples of these models have already been described in Chapter 4 (Section 4.4.2) and the purpose of this section is to uncover the knowledge involved in getting to know carers beyond the instrumental and shared aspects of care described by Twigg and Atkin (1994).

There is growing interest in current literature on the 'family' as the focus for nursing interventions (Wright and Leahey 1994; Whyte 1997). Originating from North America, family theory postulates that the nurse can carry out nursing at three different levels:

Level 1 'Family as context' where the nurse views the family as the context of care for patients. The patient's needs are predominant and the function of the family is as a social network.

Level 2 'Interpersonal family nursing' involves the nurse in spending time with one or more family members depending on their needs. Relationships within the family may be explored so that knowledge of support systems can be uncovered.

Level 3 'Family systems nursing' differs from the other two levels in that the whole family is regarded as the 'client'. Interventions aim to bring about changes in the whole family system and require the nurse to assess the impact of the illness on the family and the

influence of the family interaction on health (Friedman 1992; Wright and Leahey 1994; McCormack 1997).

It has been suggested that despite the importance of the role of the family in health, the concept of family nursing is not central to community nursing in the United Kingdom. McCormack (1997) claims this might be due to the widespread application of the Roper et al (1996) model to nursing practice. Although this model emphasises the importance of seeing a person within their social context, the framework lends itself to a more individualised approach to nursing (Roper et al. 1996; McCormack 1997).

The data revealed that where ongoing care was likely to be required, the DNs were functioning at level 2 as described above. In straightforward cases, such as wound management, intervention at level 1 may be all that is necessary and further intervention could be viewed as intrusive. Throughout, the DNs talked about the role of the family and the impact of the patient's illness on them and the textual accounts allude to negotiating and balancing interventions to meet the needs of different family members (level 3). Where appropriate, the DNs were conscious of trying to elucidate and meet family needs. There was evidence of the DNs trying to establish a picture of the relationships and dynamics that existed within the family and thinking through flexible patterns of interventions.

Descriptions of particular clinical episodes revealed the efforts of the DNs to grasp the situation in relation to the carers' perspectives. Understanding how the carer was experiencing the particular clinical episode required to be balanced with the expectations of the patient, carer and DN as to the contribution of the carer to meeting patient needs.

Recognition that the DN had a part to play in supporting the carer was clear and DN 1 said she made a conscious effort to ensure the carer knew she was there for them:

"I think I always say to them that I am here to help your loved one...partner or whatever but I am also here to help you because it affects everyone in the household...I mean that's the main thing I always do with carers - I am here to help you as well and I appreciate this is hard going for you and we can look at ways to help - this is what is on offer if you feel... because quite a lot say 'Oh well I am fine at the moment' but I think it's good for them to know that you care about them as well - it's not just about this person (the patient). I think the carer's needs are very important and often its just knowing that someone is there to help them - knowing that someone is there does help them - knowing there is someone you can call on - 'here is my number you must phone me, don't feel frightened to phone me. If I can't help you then I'll get someone who can'..." (DN 1:2).

Supporting carers was considered to be an important function of the DN role. The DNs described a role that encompassed understanding what it means to care so that appropriate support could be offered and active negotiation carried out with the carer about how the patient's care needs could be met.

Two broad categories of getting to know the carer emerged as vital to DN assessment practice – getting to know the carer's patterns of responses to the particular clinical situation of the patient and getting to know the carer as a person. These categories reflect those described above in relation to getting to know the patient. However, there are inherent differences, as getting to know the carer as a person was rather more to do with understanding how the illness was impacting on the carer in order to negotiate the boundaries of the caring role, than with identifying specific carer needs.

Getting to know the carer's pattern of responses – how they 'managed'?

Getting to know the carer's patterns of responses to the particular clinical situation of the patient involved knowing if:

- The carer's perspective of the situation matched the patient's
- The carer was managing certain caring tasks or not
- The carer was able to maintain the physical environment of the home or not
- The carer was concealing their stress

Getting to know how the carer was responding to the particular clinical episode of the patient involved understanding what it meant to care for and live with the patient. The recognition that the carer was an important source of information about the patient was coupled with the realisation that the picture presented by patient and carer could differ:

"I think that the patient could give you one story and they (the carer) could give you another story so I think you have to weigh that up...I mean the patient might say they are fine and then you get the carer at the door and they say but he is up all night and he is wailing and howling and you have not heard that from them. So it is important that you do involve them..." (DN 10:2).

The recognition that sometimes the family carer may try to conceal the full impact of the patient's clinical condition has implications for the DNs who described how important it was to build the whole picture:

“...I have a patient just now who is a chronic patient who is elderly - he is looked after by an elderly wife and I know fine that she will say to me everything is okay even if she is on her knees crawling about. And he’s away with the fairies so I’ll not get a picture from him. And I mean there is carer (social work) goes in the morning to get him up and dressed and I am saying to her (the wife) - you are managing okay, he’s sleeping and the (social work) carer is going like this - no - and she’s (wife) oh yes everything is fine...” (DN 8:2).

There was recognition that carers may respond in different ways to the illness of a loved one. Recognition that carers may have found it embarrassing to admit that they were not coping made it difficult for the DN to challenge the carer if the DN’s perception of the situation did not match the information being imparted. Being a guest in the patient and carer’s home precluded the DN from openly challenging them, but rather involved a process of ‘getting to know’ which could facilitate negotiation and compromise. Respecting the carer was an important indicator of value-based knowledge. This type of knowing was identified in the literature review as largely invisible but was discernible and demonstrated in the actions of the DN.

Getting to know John

DN 1 visited an elderly lady to assess her for bathing. Throughout the interview the DN referred to the needs of the carer and how she was not quite sure what the situation was.

When the DN and researcher arrived at the home of the patient, the carer (John) was busy washing soiled bed clothing. The smell of faecal incontinence was strong and the patient was in her bedroom putting on her clothes. The patient told us that she had diarrhoea and vomiting that morning. The patient was helped to complete dressing and assisted through to the sitting room. The carer remained in the kitchen and only came into the room after the DN had been present for some time. Although the carer said very little at the visit the DN referred to John several times throughout the interview and how she thought he was stressed by coping with his wife’s illness.

DN 1 had visited this home on one previous occasion around a year earlier and said prior to the visit she thought that something must have changed since then. At interview she said that her first impressions were that there had been no significant change:

“The same situation (existed) where the main carer (was) very laid back in appearance and ‘oh I’ll manage’, that was very much as before, and the lady herself – not much appeared to have changed immediately by looking at them both. In other words I didn’t go into a

really stressed household where they were definitely not managing...I think the main thing was ...the woman's husband...appeared as though he was coping but in fact I would say he could probably do with a bit of help in some way, even if it is just to get a break as opposed to any physical help...I had an inkling that she could maybe do more for her self than she initially said and relied very heavily on him and he has got into this thing where he just does everything for her without really thinking about should I ...is this completely necessary or how can I save my back, because he was complaining of a sore back”.

Not being able to fully understand how the carer was coping with the patient's illness complicated the assessment process for the DN who could not grasp fully the salient issues arising from the situation. DN 1 explained why she decided to return the next week and go through the bathing process with the patient:

“...because I needed to know what she could and could not do for herself . I can't tell by just looking at her. I looked, I watched her mobility and it wasn't that great so I have an idea that she is not going to be whizzing in and out of a bath so I have an idea she might have a few problems. She said she could wash at a sink, how well she does that I don't know, she said that she could dress herself, well she was dressed but I get the impression...yes it would take her a while. But I really need to know how much she can do for herself so that I know what's appropriate to put in there. Is it different bath aids, is it – yes- he will manage if we teach a different method? You are talking about her standing on a stool and getting into the bath - I actually immediately think that is not the best way for anybody to get into a bath with him holding on to her while she balances trying to get into a very deep bath. I actually immediately think that is not good and not safe for either of them, and not the best way to use, you know use each other. So I would like to see how they do that so that I can look at safety, look at whether it's appropriate that a nurse goes in or not and also I want to see if she can do it herself...she said he does it for her and yet she says she can wash at the sink. So we are getting conflicting stories here and I need to know what is happening before I can make a decision about what we put in, what kind of resource we put in”.

In addition to understanding the extent to which the patient could meet her physical hygiene needs, DN 1 tried to assess how John was coping and how he and his wife could be helped in the future. Although there was recognition that they had developed some strategies for coping, the DN still had to determine what these were to see if she could offer an acceptable, improved alternative.

Getting to know the carer as a person

Getting to know the carer as a person involved understanding how the carer felt about the clinical situation of the patient. This understanding allowed the DN to negotiate care and support for the patient without alienating the carer.

DN 4 described the response of Margaret to her husband's terminal illness. The strategies employed by the DN to meet the needs of patient and carer were consciously deliberated. DN 4 described the situation where she had to work hard at understanding the carer's response to her husband's illness. To do so involved getting to know the carer (Margaret) as a person and gaining her trust and confidence. The patient was a middle-aged gentleman who had advanced Carcinoma of the Lung. The DN was not asked to call until the patient was very ill and Margaret initially refused her access to the house. DN 4 eventually gained access to the house, and saw the patient but described the difficulties in caring under these circumstances:

"...and that was really quite a shock to the system and I didn't really know what to say to her and really it was because...she knew me in the town and her husband knew me and I knew the husband and she was ashamed of me meeting her husband...he looked so different from when I had last seen him.

I went to this house with very little information because the GP already had the notes out...all I knew was he was a CA of lung and needed help...being met with that at the door...obviously influenced a lot of the way I behaved and how I worked my way into the house and had to speak with them and how I could get them round to accepting me - you know into the house...the whole time I looked after that man everything was done very carefully - everything I did I had to think carefully about what I was doing and why I was doing it because I was aware that she was very much - you know thinking about what I was going to do - even to the giving of an intra-muscular injection which she questioned because she thought I was giving him euthanasia, you know she knew what would happen if he had this injection - so it was quite difficult.

I had to do it really slowly - that day I did speak to her just for a few moments and you know, I asked if I could meet the husband and he was actually nothing to what she had said - it was her feelings - she was ashamed of the way he looked whereas he was actually fine at seeing me - in fact we got on really really well - but I had to work very slowly with her and everything I did I had to explain to her everything I was doing - why I was doing it - when I was going to do it" (DN 4:2).

Here in responding to the carer, the DN is influenced by:

Knowledge of the diagnosis

Sensitivity to the carer's feelings

The carer's questioning, possible anxiety/uncertainty about the DN's actions.

The DN decides to tread gently and to 'work her way in': to get the carer's acceptance of her first. Understanding how her husband's deteriorating health affected Margaret was important. The DN had to understand the impact of the changes in the physical appearance

and social roles of her husband on Margaret. DN 4 adopted deliberate caring strategies to meet the needs of both patient and carer.

The DNs were sensitive to responding to the role that carers might wish to assume in caring for family members. DN 7 described how she approached a situation where she knew that the wife and daughter were both nurses and was not clear what these carers would expect of her:

“...the patient was terminally ill and his wife was a nurse and his daughter was a nurse and I had known his daughter...the fax we got was ‘could we go in as a support visit - both wife and daughter are happy to (care)’... so I thought how I would be in that situation and if it was me...say it was my mother or father - I would want to care for my father or mother totally by myself probably or do everything I could. I suppose in that respect I was going in there - I wanted to know what their agenda was - what they really expected of me – that, yes, I was here to do and care for their father in whatever way but I felt I had to take a back step and she actually said - well you know all about the bits and pieces that happened to my dad and I am just a daughter tonight and I want you (to help)...I wanted them really to say to me we want you to – (or) not to do (certain things) - but I did not step on their toes - I was sort of feeling my way...I went in there knowing they have previous knowledge and it’s a difficult situation and I think in a different situation, say, where the carers were not nurses I would still take that same approach” (DN 7:2).

Knowing that the carers were nurses alerted the DN to the fact that they would have professional rather than lay understanding of the patient’s circumstances. She recognised her own values but identified her willingness to fit in with the agenda of the carers. The DN recognised that for some people, active participation in care was important. However, if the family felt they could no longer cope with all the caring activities, the DN was happy to intervene.

The DN’s in this study identified that throughout the illness trajectory, their contribution to the overall care of the patient was likely to change. For example, patients and family carers who required palliative care may need support but no physical care in the early stages of the illness. As the patient’s condition deteriorates, the carer may need help with additional caring activities (although in some cases the interventions of the DN may remain at the supportive level throughout the illness). Responding to the carers as people with different values and attitudes individualised the DN/carers interaction.

The need to understand the dynamics that existed in a family was evident from the data. McIntosh (1996) has suggested that caring at home requires a sound understanding of

social structures and networks, of interpersonal skills, and the psychosocial needs of families experiencing illness, disability and death. The DNs recognised that different relationships existed within families and understanding family dynamics was an integral part of the assessment process and subsequent decision-making. The need to avoid making assumptions about the relationship which existed within the home influenced the approach of DN 3, who said:

“Well, it is difficult to (explore some areas) - for example incontinence - if there is a spouse there, perhaps because that might be a delicate area. But you know married couples don't like to discuss (some issues) in front of each other... You would not use the same words that you might use if it was just you and the patient so there is that and also if there was somebody who was in a terminally ill situation needing palliative care and the spouse wasn't accepting it or the patient wasn't accepting but you know its a sort of 'does she know that I know, does she know' kind of situation. So I would use different language. I would try and be more delicate in certain things if there was a third party no matter how close the family member was” (DN 3:2).

This example illustrates links between theoretical and practical knowledge:

Knowing that: There are delicate/sensitive issues in relationships
 There is a need to assess degrees of openness within relationships
 Privacy and confidentiality need to be respected

Therefore, the DN needs to **know how** to broach topics and talk about delicate matters in order to:

Judge whether an issue is sensitive or not between family members
 Judge whether free open communication is possible/appropriate
 Be able to use an appropriate form of discourse and language.

Recognition of the relationships which existed in the family influenced the DN who tried not to make assumptions that it was permissible to talk about sensitive topics in front of family members. Family systems theory outlined above, emphasises the importance of the nurse assessing family needs and planning future care with the family unit rather than focussing solely on the patient.

DN 3 thought that getting to know the carer involved:

“...an appreciation of how important people are to each other and how precious this relationship can be and how you are very much the invited guest – you can show empathy and caring, respect and feel very privileged to be a part of that”.

DN 4 described how she was able to identify the feelings and moods of family members from the actual visit:

“I think it is very important to pick up vibes in houses whether it’s with the carers or other parts of the family - if you observe them or listen to what’s going on you can soon pick up the feeling that they are being left out or they are not being involved in something or they are worried about something or they want to talk to you about something. Perhaps when you know their mother is actually not there... because when you are in someone’s house lots of past things can build up with families and it is very very important to feel the vibes - you know is it a happy family? is everybody comfortable with what’s going on?...is there any anger?...is somebody blaming somebody for something? There’s a lot of different things and I tend to find that you can pick up on it if you just listen to how they speak - watch the way they act - do they never go near the room?...are they staying away? Every time you go - you find this with sons and daughters you go to the house and they just disappear into the kitchen with the door shut and the wife will say ‘don’t tell my daughter’ – ‘don’t tell my son’ – ‘don’t do this or that’ and you know the son or the daughter can pick up on that and then...you’re getting the blame because you know all that’s going on but you’re not telling them because Mum doesn’t want them involved in it. So vibes are very very important, you have to pick up on anger and happiness” (DN 4:2).

Acting as mediator between different members of the family meant getting to know and understanding their varying moods and feelings. This account suggests that DN 4 had learned through experience how to understand family member’s feelings and reactions to illness in the house.

In complex family dynamics the DN could experience divided loyalties between the patient and other family members. Although the DN often identified with one carer who assumed the main caring role, there was recognition that including other family members in decision-making was difficult but essential to caring for patients at home:

“I think you have to involve them and you have to.... and it’s bad nursing, I think, to try and take over because the first people that are left out are those on the perimeter... children of the family or the grandparents...they can feel very very left out of the decisions (and) what you are doing... It really is important to involve them as much as possible. I had an incident not long ago with a young lady that died and afterwards, on looking back, I could see how they (the patient’s parents) were really quite grieved because the husband and the children were kind of really the priorities there and her parents were on the periphery and they were not really being involved in everything that was going on - decision-making...so you have to pull them all in so that no one is feeling that they are being left out” (DN 4:2).

Involving family members in decision-making and balancing this involvement with respect for the patient was important.

DN 3 identified that it was important to avoid making assumptions:

“...it’s just trying to clarify from day 1... “do you live here – yes -... Are you happy to be here with so and so or are you happy to help” and it does not take long to ask that but if you don’t get that bit sorted out from day 1 you are on a sticky wicket...because very often, you will know yourself, people just assume a wife will look after a husband but there are certain things that that person maybe feels they just could not do, no matter how much they love somebody - so its good to clarify all that at the start” (DN 3:2).

Getting to know the carer as a person, involved, knowing if:

- The carer was coping with the physical and emotional challenge of caring for the patient
- The carer was coping with their new/altered role within the family.

In summary, getting to know the carer was a significant pattern of knowing in district nursing practice and central to skilled clinical judgement. Getting to know the carer required the DN to understand how they were responding to the particular clinical situation of the patient and to have respect for their specific contribution to the patient’s care. Getting to know the carer as a person involved understanding the how the carer was adapting to, and coping with, the caring role. The DNs responded to the agenda of the carer and individualised their interventions by ‘being there for support’ for carers.

It is noteworthy that recent studies which have focussed on uncovering the knowledge embedded in clinical practice, have made scant reference to the contribution of family carers. Although Macleod (1996) and Benner’s work (1984) was focussed in the hospital setting, it is surprising that the family is barely acknowledged. Understanding the patient as part of a broader social network seems essential if nursing practice is to embrace the holistic approach to practice advocated in current nursing literature.

This exploration can only give a very small insight into the knowledge embedded in the practice of experienced DNs in relation to getting to know the carer. If this part of the DN

role remains unrecorded by practitioners themselves, this will restrict the potential for uncovering and learning more about the practice based knowledge of DNs.

5.2.3. Knowing what needs to be done now

Knowing what needs to be done now involved:

- Recognising the expectations of the patient
- Recognising and prioritising between problems to be dealt with there and then, and those that could be left for the future
- Prioritising actions, for example, relieving pain and discomfort by changing a dressing.

At 6 of the visits observed, the DN had to assess and dress a range of wounds. The field notes confirm that in response to the patient's actions and cues, all the DNs undertook this task quickly after entering the house. The patients revealed dressings, removed clothing or moved to an appropriate part of their home such as a bed or couch and the DNs responded by completing the task. There appeared to be an implicit understanding between the DN and patient as to the purpose of the visit.

For example, DN 10 visited a 48 year-old man to dress an excised abscess. On arrival at the house and after preliminary introductions, the patient, who had bilateral amputations, started to put his artificial legs on as he 'thought it would be better if we went upstairs' for the dressing to be done. The DN started to chat to the patient about 'what had been happening to him' and followed his lead upstairs where the dressing was completed. At the follow up interview the DN identified that she had visited this man around a year ago for a similar reason:

"I was quite amazed how well he manages with everything, that kind of struck me that he was completely at home with his disability...he doesn't seem disabled at all...That was the main thing that struck me...there wasn't anything else that was a surprise to me...I didn't feel it was necessary to ask him if he was managing day to day living... I mean I think when they have got an abscess down there I always ask them about their bowels because they sometimes have a problem or if they are passing urine all right" (DN 10:1).

It might seem surprising, given that the patient had undergone a bilateral amputee, that the DN did not enquire how the patient was 'managing'. However, observation of the visit

confirmed that several adaptations had been made to the patient's home and he was fully mobile. On arrival at the house, he was working at a computer and talked freely about his wife who was at work. Throughout the visit, the patient was pleasant but was reluctant to accept that a DN should visit over the weekend to dress the wound (visited on Friday afternoon):

"I just feel that it's better to just keep the wound open to drain. And I think I explained that to the patient that was the reason for us coming in...not that we wanted to generate work for the weekend but we felt it was important to keep that (wound) open so that it healed properly and not filled up again and end up with the same problem" (DN 10:1).

The DN knew that it was essential to ensure that the wound healed properly and she knew what had to be done at the visit. She was sensitive to the patient but a compromise was reached where the patient understood, and accepted, the need for visits at the weekend.

At the visits observed where the assessment task was a general assessment of hygiene needs (DN 3 Chapter 6) or continence status (DN 9 Pg. 168) a different approach was evident. At these visits the DNs sat down and talked to the patient before any action was considered. DN 3 bathed the patient after she had gathered some information and DN 9 did not carry out a specific task but left the visit intending to gather further information.

Where different circumstances prevailed, the actions of the DN were responsive. DN 1 also assessed a patient for bathing and on arrival found the patient recovering from a bout of vomiting and diarrhoea (Pg. 176). In this case the DN helped the patient to finish dressing, enquired about what had caused the problem and then accompanied the patient to her living room. Only when the patient was comfortable and able to respond, did the DN begin to ask for information relating to the referral.

At the first visit, the DN had to interpret the information available from the patient and the context and prioritise what needed to be done there and then. Given that the reality of the situation encountered by the DN often bore little resemblance to the referral information, interpretation and prioritisation was a vital and reflexive part of the assessment process.

The DNs described in detail how they set about establishing a relationship with the patient and carer and the importance of doing so at the first visit. They also emphasised the need to avoid the first visit becoming an interrogation. However, they recognised that tasks might

have to be completed before searching for the information needed to inform further care planning. Similarly, by responding to the cues given by the patient about their expectations of the visit, the DN individualised the interaction.

5.2.4. Knowing what may happen in the future

Knowing what might happen in the future was identified in the early stages of data analysis and formed an important aspect of anticipating future care needs (Chapter 4 Section 4.4.4). Anticipation may be defined as the expectation that certain events will arise which allows action in advance to forestall (or lessen) the impact of that event (McLeod 1987).

Knowing what might happen in the future was based on possibilities rather than absolute certainty. The DNs anticipated in some cases that the combination of a particular clinical situation of the patient, with certain psychosocial aspects of the patient's life, was likely to result in future care needs. The degree of certainty related to the problems. In straightforward tasks, such as assessing and dressing uncomplicated wounds the DN could predict future care needs with reasonable certainty and could decide that no further visits were necessary. More complex tasks, such as assessing the hygiene needs of frail elderly people and assessing chronic wounds were likely to be multi-faceted and resulted in a higher level of uncertainty on the part of the DN and less confidence in decision-making. In the latter situation, the DNs were likely to arrange a further visit to collect more information, assess physical functions (e.g. abilities to get in and out of bath) and/or keep in touch with the patient to monitor the condition. In such cases, the intervention was 'paced' and recognition given to the uncertain nature of the situation facing the DN.

In everyday practice, the DN must decide on the basis of the best available evidence whether there is a need to return or not. Given the complex processes already described in Chapter 4 in relation to building a picture at the first visit, and making sense of the evidence, anticipating future care need involved estimating how certain or uncertain they were about the particular situation of the patient.

Bowers (1987), in a comprehensive model of family-based care, differentiates care by purpose rather than task. Anticipatory care is based on the premise of 'just in case'. There is limited discussion, however, of the concept of anticipation as a component of skilled nursing practice. Nolan et al (1995) extend Bower's conceptualisation of anticipatory care,

distinguishing between speculative and informed anticipation. Speculative anticipation is based on limited knowledge and the carer may therefore over or under anticipate possible future care demands. As informed anticipation is likely to be based on adequate knowledge, this supports more accurate identification of future care needs (Nolan et al. 1995).

For nurses in clinical practice, it seems likely that anticipating future care needs, given the inherent degree of uncertainty in many situations, is based on an amalgam of information and speculation. The clear distinction proposed by Nolan et al (1995) has limited application to some of the multifaceted situations encountered by the DNs in this study as the examples given below illustrate. Although the DNs had information about the patient and their situation, they could not predict with certainty the outcomes in the future, and therefore seemed to combine a degree of speculation with the information available to inform their decision-making.

Current literature focuses on problem-solving approaches, which presuppose a systematic approach to care and access to a body of research to guide the practitioner to select the 'best' intervention for their patient (Taylor 1997). Alternatively, intuition as a mode of cognition is seen as the hallmark of expert practice and the quality of decision-making that results from this mode of cognition is rarely challenged (Benner 1984; Rolfe 1998). It could be argued that nurses expect that there will be a correct solution to each problem. Overconfidence by nurses and physicians in deciding clinical interventions for their patients has been identified by a number of studies and has implications for the quality of patient care as the views of the patient are seldom included (Baumann et al. 1991).

The renewed emphasis on evidence based practice (National Health Service Management Executive 1994) reinforces the message to nurses that the 'right' answers are available if they look for them. However, many of the situations encountered by nurses are uncertain, not least because of individual patient responses and preferences and because there are a range of actions which the nurse could take in any given situation.

Knowing what *might* happen in the future as a component of DN assessment was based on understanding and knowledge of previous cases and the anticipation that a certain pattern of events *could* unfold.

Knowing what may happen to Margaret in the future – estimating risk

DN 4 was asked to visit Margaret to take her blood pressure. Margaret answered the door to the DN and the researcher. Margaret was 77 years old and walked with the aid of a zimmer frame.

DN 4 said:

“...I think the lady with blood pressure...I went in with ideas about her straight away because obviously she has a problem (with high blood pressure)...she was on her own, she has obviously had high blood pressure for some time. Her last tablets were making her quite sick, she is obviously much happier on the medication she is now on ...you take in the living conditions which were quite good, she was a very happy lady ...I think the good thing about the visit was that in the future this lady could have problems and it was quite nice to have met her and for her to meet me. It may be one that I will go back and see occasionally...when I am passing...I would like to go back and see her because she is the kind of lady that does not have support. Picking up on the fact that her daughters both live away down South...so she does not have any relatives (nearby) and did not appear from what she said to have many visitors...she did not appear to be a very fit lady. I think there may in the future be some other problems”.

Knowing that increased blood pressure on a long-term basis was problematic alerted DN 4 to the possibility that Margaret might suffer a range of health problems. Her judgement here was a degree of risk to health in these circumstances and although the patient was managing at present, the situation could change at any time. She was concerned that Margaret was socially isolated and anticipated that any change in condition could be missed unless Margaret herself sought help. Whilst DN 4 anticipated that her patient could have future health problems, there remained uncertainty as to whether in fact her opinion would prove to be correct. For example, the patient's blood pressure could remain stable and cause her no further problems. Whilst her family did not live locally the patient may have adequate sources of support.

Knowing what may happen in the future involved:

- Knowing that the physical condition of the patient might predispose to future health problems and care needs
- Knowing that the amount and nature of social support available to a patient might predispose to future care needs

- Making a judgement about the anticipated illness trajectory based on the perceived certainty/uncertainty of the situation. In other words, the DNs weighted certain pieces of information (cues), estimated risk and judged that certain events were likely to unfold
- Seeking confirming/disconfirming evidence to support the hypothesis formed by the DN (this might include actions such as bathing the patient to confirm ability to manage).

In summary, knowing what may happen in the future formed a core element of the assessment process in district nursing practice. Uncertainty is an inevitable part of clinical practice and the strategies adopted by practitioners in dealing with uncertainty are illuminating for DN practice.

5.2.5. Knowing/recognising knowledge deficits

“Unknowing, paradoxically, is another pattern of knowing. Knowing that one does not know something, that one does not understand someone who stands before them and that perhaps this process does not fit into some pre-existing paradigm or theory is critical to the evolution and development of knowledge” (Munhall 1993 Pg.125).

Awareness of knowledge deficits had two dimensions in district nursing practice. The first dimension related to the patient and their situation where more evidence was required to allow the DN to build an assessment picture. Secondly, the DNs recognised that as their role diversified, due to the changing patterns in healthcare delivery, they were encountering an increasing number of unfamiliar situations that demanded a range of new technical skills and specialist knowledge; for example, situations such as caring for patients on ventilating equipment and undertaking nurse prescribing.

DN knowing she needs more information about the patient and their setting

Firstly, whilst the first visit involved collecting factual information from the patient and carers, there was agreement that this visit should not result in an interrogation, and that the information search should be paced, and possibly restricted. Collecting certain information might be ‘beyond the boundaries’ at the first visit (Chapter 4, Section 4.1.3). Secondly, it was sometimes not possible to discern the physical condition or the physical capacities of the patient from one visit.

DN 7 was visiting a lady with weeping cellulitis of one leg. When asked why she had decided to make a return visit the next day she said:

“...it’s a bit of instinct but I feel...it’s leaking ...and it might actually leak more from the front and I just thought rather than leaving her it’s better to check her daily until we know for definite that the leakage is subsiding. I don’t know what the leakage is like. I mean she had a pad on, which was really quite bad but this is the first time I’ve visited so I don’t really know and I just think you are better to be on the safe side than leave it”.

Although she attributed her decision partly to instinct, DN 7 knew that she did not have enough information from one visit about the volume of leakage from the patient’s leg. A return visit the next day would allow her to build on her assessment and determine future interventions.

DNs’ 1 and 3 assessed patients for bathing. The DNs acknowledged they did not know enough about the functional capacities of the patient to make an informed decision. DN 1 reported that she could not tell by just looking at the patient what she could or could not do for herself. She judged that due to her limited mobility, she would not be ‘whizzing in and out of a bath’. The patient told the nurse she could wash at the sink but the DN was not convinced how well she would do that. The DN also thought that the way the patient and carer described using a stool to get in and out of the bath was unsafe. The DN thought she was getting conflicting stories and said “...I want, I need to know what is happening before I can make a decision about what we put in, what kind of resource we put in”.

During the visit to assess an elderly gentleman for bathing, DN 3 carried out the task at the first visit. At interview she said: “...I really cannot see how you can do a bathing assessment without having a go, seeing how the person performs in the bath”.

These examples highlight incidents where the DN needed to know more about a patient’s physical condition and capacities to inform decision-making. Being aware of knowledge deficits and of the need to know more in particular situations seems an essential attribute of professional practice, as overconfidence in knowing could lead to premature closure by the DN in their search for information.

The influence of the context and the nature of the DN/patient relationship in this pattern of knowing are important, as the DNs made judgements about those areas of the patient’s life that were appropriate to explore at the first visit and those that should be left for future

visits. This also included giving more time to assess clinical aspects of the patient's care. This pattern of knowing may be partly explained by the concepts of bounded rationality and the temporal unfolding of information.

Bounded rationality recognises that the individual has limited capacity for remembering, gathering and processing information (Elstein and Bordage 1988). In other words, we can only deal with so much information at any given time. Given the complex and multifaceted situations sometimes encountered by DNs, the collection and interpretation of information needed to be paced. This may explain why the DNs appeared to search for a 'main thing' at the first visit. Also, building up information was akin to a temporal process and a delicately balanced interaction between DN and patient. There could be limits to both the DN's search for information and to the amount of information that patients and carers might choose to reveal at the first visit (Barrows and Feltovich 1987).

DN knowing she needed additional technical skills and specialist knowledge

The DNs reported a changing role as a result of implementation of the Community Care Act (Public General Acts 1990). For example, policy changes meant that work formerly undertaken by DN's such as meeting general hygiene needs was now undertaken by Social Work Carers. Additionally, as outlined above and identified below by DN 8, the DNs were involved in caring for patients with more complex needs and, whilst they welcomed role expansion some knowledge and skills deficits were identified:

"...I mean our role has completely changed, I think. The majority of our work would be in wound care or terminal care or in an advisory capacity with MS or whatever...we are being asked to cope with a lot of things that we are not confident with as well, like the gastrostomy feeds...the PEG tubes...for example; Joyce has a ventilated patient. I mean I haven't worked with a ventilator for years and yet we are being asked to be in supervisory capacity over that kind of patient without any training...or sort of update. So although it is quite exciting in some ways it's also really frightening in others because you are really frightened you get out of your depth" (DN 8:1).

DN 8 identified deficits in her skills and knowledge base and the lack of support from specialists in the community. Caring for a young man with multiple sclerosis who had deteriorated, led DN 8 to contact the specialist nurse for advice. She discovered that the post had been cut, thus removing a source of expert advice. A similar scenario was also reported by DN 9 who identified childhood constipation as being difficult to deal with due

to her own lack of paediatric experience; there was no paediatric community nurse in the area.

Knowing/recognising knowledge deficits involved:

- Knowing that more information about a patient was required to inform care planning
- Understanding that specialist knowledge might be necessary for some conditions
- Knowing how to access specialist knowledge and skills.

Study participants had varying educational backgrounds (Table 1 Pg. 77) and the methods by which they were updating their knowledge and skills were individualised and ad hoc. There was general agreement that in-service training opportunities had increased but there was little evidence that training programmes were based on identified need.

In order to prevent premature closure of the case, the DN has to assume a condition of openness that allows her to build an understanding the situation of the patient. Understanding and exercising judgements about the type and amount of information that can be gleaned from the first visit is a dynamic and individualised activity that is informed by the context in which the visit takes place. So too was knowing what additional information would be required to inform future decision-making and actions. Knowing personal limitations is vital as the DN role extends to incorporate new and complex situations. This has implications for the education of present and future DNs. General Practitioners in the community have access to specialist advice from medical counterparts. It could be argued that DNs, who are assuming an increasingly diverse role, require the same support network.

5.2.6. Knowing the community resources and services

Having knowledge of services and equipment available in the community was important, as the DNs tried to meet the needs of patients and families within available resources. Although underpinned by knowledge of recent policy changes and their impact, this knowledge was localised and specific to the areas in which the DNs worked.

For example, the DNs required to know how to contact other caring professionals including social workers and occupational therapists. In particular, they were

communicating increasingly with the social work department, as some patients were receiving care from both social services and community nursing.

The DNs also needed to know the range of equipment available to help and how to access this for their patients. Additionally, the DNs had to investigate the financial status of the patients to inform their decisions regarding eligibility for the help of the DN service.

Knowing the community involved knowing that:

- There could be limitations to availability of equipment and services
- A match might not always be possible between patient/carer need and available resources
- Some patients had needs which could be met jointly by health and social services
- Demographic changes had resulted in larger numbers of elderly population requiring care, a trend projected to continue
- Some patients would have to pay for certain services (for example home helps, bathing service).

“Knowing the community” was a knowledge base informed by policy changes and knowledge built up over time of the resources available in the local area. Increasingly, the DNs now have to consider a wider range of options in relation to meeting needs including negotiating aspects of care with private agencies on a fee-for-service basis.

Also, knowing the community extended beyond the equipment and services available. It incorporated knowledge built up over time of people and families in the community. The DNs frequently alluded to their localised and particularised knowledge of the area in which they worked. Knowing the community involved the DNs in establishing working patterns with other professionals in order to meet the needs of patients and carers.

5.2.7. Conclusions

This typology provides a framework that can illuminate the knowledge base of the DN participants in this study. The six ways of knowing, distilled from the data, offer a conceptualisation of practice based knowledge in district nursing practice and illuminate the integrated knowledge base displayed by the study participants. Recognition that this

knowledge base is complex and connected to the context in which the DN/patient interaction occurs, is crucial to further refinement.

As discussed above, it was difficult within this study which took place in the “real world of practice” to discern the different ways of knowing as mutually exclusive categories, characterised in current literature (Carper 1978; Rolfe 1998). In particular, it was not possible to clearly identify theoretical knowledge as a distinct category. This does not mean that the DNs did not possess such knowledge but rather that it had become contextualised and part of knowing in practice (Macleod 1990; Luker and Kenrick 1992; Macleod 1996).

The typology requires further empirical study to test and refine its parameters. It is proposed that further exploration of these ways of knowing in DN practice may help to further uncover and illuminate the practice based knowing of district nurses.

5.3. Introduction - Decision-making in district nursing practice

The literature review (Chapter 3, Section 2.4) identified two main approaches to decision-making; prescriptive approaches which are concerned with how decisions *ought* to be made and descriptive models which describe how decisions are *actually* made (Thomas et al. 1991). This study has revealed important information about *how* decisions were actually made although the conceptually separate question of *how well* they were made could not be addressed, as the study did not extend beyond the first visit.

The data revealed that during assessment, the DN has to decide:

- The content of assessment: what to observe/look for
 what to ask/enquire about
 how much to include/enquire about in the assessment
- Whether to, and how to, include the carers in the assessment
- How to avoid the assessment becoming an interrogation

In relation to care giving and planning the DN has to decide:

- What to do there and then
- If she should revisit and if so, when next and how often
- Whether other members of the nursing team should help
- Whether she should refer to others, and if so, to whom

In the current study three main outcomes of decision-making were revealed:

- 1 Clear outcome: characterised by certainty
- 2 Temporal evaluation: characterised by uncertainty
- 3 Mixed outcome: a combination of clear outcome and temporal evaluation for different aspects of care.

In straightforward cases where the DNs could predict with certainty the illness trajectory, they were able to make clear outcome decisions that those patients did not need to be visited again. Where the cases were more complex and the illness trajectory more

uncertain, the outcomes were likely to be temporal and evaluative or result in a mixed outcome (Chapter 6). Straightforward tasks allowed the DN to utilise deductive cognition and more complex tasks involved inductive, or both inductive and deductive modes of cognition.

5.3.1. The decision-making process in district nursing practice

Bryans & McIntosh (1996) in critiquing the work of Carroll & Johnson (1990), suggested that the latter's conceptual framework, distilled from the work of various theorists, is useful for the exploration of community nurse decision-making. In particular, the predecisional and feedback stages of the process identified by Carroll & Johnson and omitted from other problem solving models of decision-making, are vital to DN assessment. The case study to follow (Chapter 6) demonstrates that the 7 temporal stages outlined by Carroll & Johnson covered the breadth of DN assessment. Therefore, the remainder of this section will focus on the cognitive skills used by the study participants in decision-making during the first assessment visit.

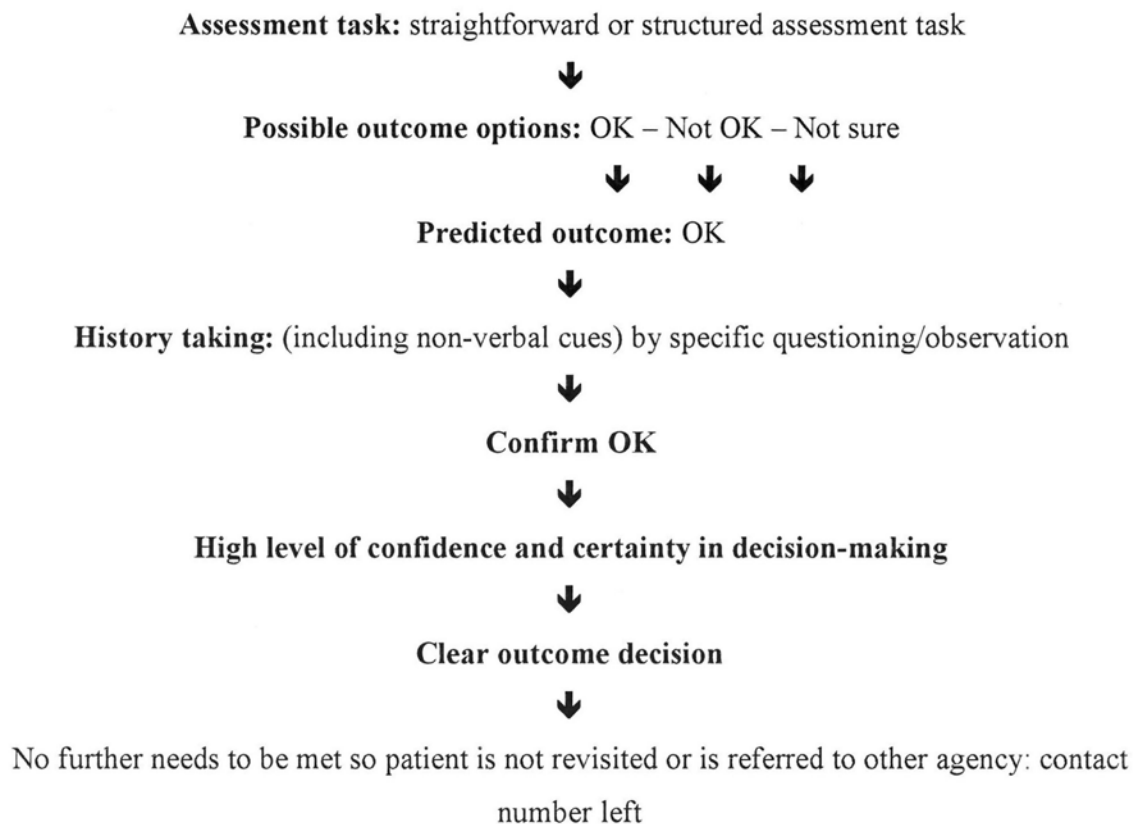
The cognitive processes of the DNs did not fit neatly into a single psychological approach that could describe their decision-making. The mode of cognition employed related to the nature of the assessment task. This claim may be explained by Hammond's (1988) descriptive theory of cognition which suggests the mode of cognition used depends on the nature of the task (Hamm 1988). This theory postulates that six modes of cognition and practice ranging from intuition to analysis can be employed (Section 2.4.1 Pg. 53) and the decision-maker should ensure that the cognitive mode is appropriate to the task situation. A discrepancy between task structure and cognitive mode is likely to result in less accurate decision-making and unsatisfactory outcomes for the patient. Medical research has demonstrated that effective problem solving requires domain or context-specific cognitive structures for gathering and organising information. These structures are developed through experience and allow expert problem solvers to limit their information search by filtering out irrelevant information (Patel and Groen 1991; Crow et al. 1995).

The mode of cognition employed by the DNs related to the assessment task and involved both inductive and deductive methods of reasoning. This resonates with findings in relation to medical decision-making (Hamm 1988; Parrino and Mitchell 1989). Inductive reasoning involves inferring a general conclusion from particular circumstances and predominates

during the data gathering phase, when the decision-maker selects and assembles specific information from cues to formulate a generalised cause or condition (Crow et al. 1995).

Straightforward assessment tasks, such as uncomplicated wounds, involved the DNs in the collection of information to confirm their judgement that the wound was healing satisfactorily and would continue to do so (Figure 3). The increased level of certainty associated with this assessment task enabled the DNs to decide that the patients required no further visits. The search for information was reduced and therefore the numbers of cues utilised in the decision-making process limited. In these straightforward visits, the DNs employed deductive approaches to make a clear outcome decision not to revisit. Given that a degree of uncertainty remains in any clinical and human situation the DNs dealt with this by leaving a contact number for patients and carers and often, as described above in the case of DN 11 (Section 5.1), advised the patient what complications to look out for.

Figure 3 Decision-making in district nursing assessment practice



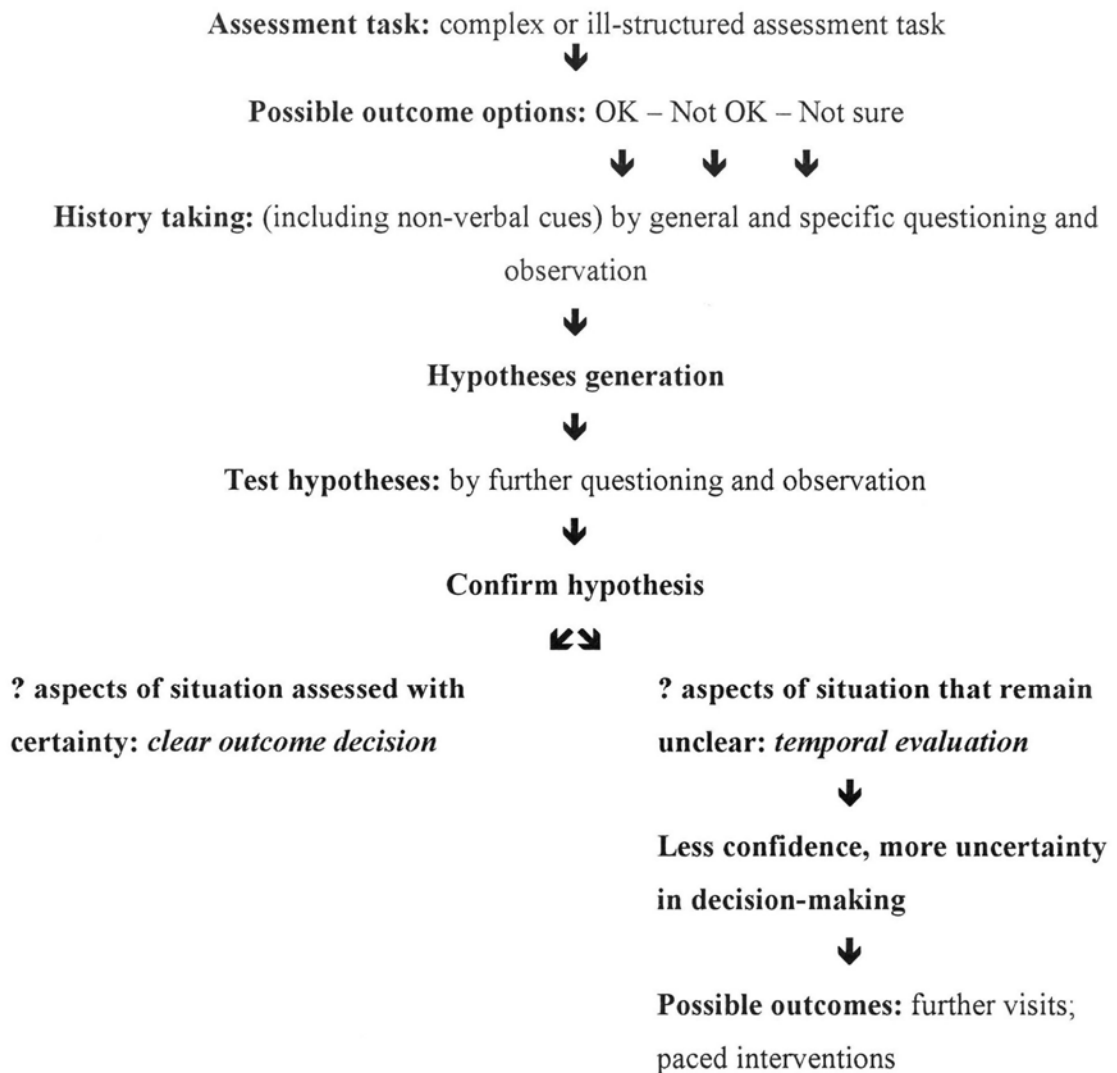
Some patients visited by the DNs resembled others previously seen. Patients visited following day surgery are a useful example. In such cases, the DNs seemed to interpret the patient's presenting signs and symptoms together with background psychosocial information, in the context of a known pattern of day surgery recovery. This general pattern was used to inform their decision-making. This enabled each DN to access a particular 'chunk' of information or domain specific knowledge relating to uncomplicated wound healing. This explanation is supported by Groen & Patel's (1985) interpretation of expert reasoning in non-problematic situations. Barrows & Feltovich (1987) challenge the existence of pattern recognition, however, and argue that it trivialises doctor's reasoning processes.

The decisions made by doctors and nurses may differ and findings from the current study would suggest that the DNs used deductive reasoning and pattern recognition in straightforward assessment visits (and for the straightforward components of more complex visits as demonstrated in the case study). As illustrated in Section 5.1, DN 11 based her judgement of a patient's situation following day surgery for hernia repair on experience gleaned from similar patients. Although DN 11 attributed her decision not to make a return visit to experience, she explained how she had learned that in cases where the circumstances were similar to those outlined above there was no need for a return visit. DN 11 recognised a pattern in the circumstances she derived from the visit.

In more complex assessment tasks, the DNs utilised inductive reasoning to collect general information about the patient and their circumstances (Figure 4). This was characterised by a broad sweep of information from a range of sources. In straightforward cases as described above, the DNs did not need to employ the broad sweep of information search necessary in inductive reasoning and so limited their information search. In more complex cases, where the current and future illness trajectory was more uncertain, the DNs moved from the broad sweep to more focussed search in an attempt to reach an overall decision about the patient's care. In such cases, the DN might not reach a clear-cut decision about her patient's needs. Rather, she might establish a temporal evaluation to avoid premature closure on identifying and meeting the needs of the patient. In these cases, decision-making was more about process than clear-cut outcomes, although as the case study demonstrates some aspects of a complex situation may be assessed with a higher level of certainty. The case study that follows demonstrates how DN 3 employed both inductive

and deductive modes of reasoning during the visit to an elderly gentleman for bathing assessment.

Figure 4 **Decision-making in district nurse assessment practice**



It is of interest, that with one exception, the DNs did not allude to intuition as being the basis of their decision-making. They offered rationales for their decision-making and recognised the temporal and evaluative nature of it in their discourse. In the one case, where a DN did attribute her actions to intuition, a sound rationale for what was done was offered, although she did not appear to recognise this.

At the time of the second interview DN 7 was working on the evening service and she related the account of a visit she had been asked to do:

“...the referral came in and again it was very basic saying ‘could you check on this lady’...she had a long medical history...I had been in two or three weeks before for bowel care for this lady and I knew whenever I walked in - this lady has got a lot of medical problems and long term problems - anyway it was really a check visit was all I was asked to do. So we were quite busy that night and there were only two of us on. ... The two of us decided to go down to see this lady and all we got really was could we check she had had loose stools during the day and could we check on her so we went in and she was in a poor condition but very adamant she wasn’t going into hospital - she was a severe asthmatic - she smoked, she was just one of these ladies who had a lot of needs - she lived on her own and I don’t know what it was but I went in and I thought there was just something that tells me it just not right”.

DN 7 described how the patient did not wish any care and how she and her colleague respected the wishes of the patient. She then goes on to describe how events unfolded:

“...I could not get her out my mind so I thought rather than actually coming back and doubling up again, I decided just to pop in and see how she was in between other visits and I walked in to...well she was actually stuck on the commode and I could see she was really quite ill and deteriorating quite rapidly and I don’t know to this day how I got her from the commode to the bed, but I did. I had to go back, just go back and see her so...I tried to get help from here but there was no help available at the time... she was still adamant – ‘I am not going into hospital’ - I said ‘well you need care and I need to get you care now’...I phoned for the GP and fortunately, for me that night it was one of her own GPs that was on...and she got admitted that night to (hospital) and unfortunately she actually died during the night”.

The DN frequently said that she did not know what took her back to the patient but the extract demonstrates she was utilising a range of information to inform her actions. The DN had visited the patient once before and recognised there had been a deterioration in her condition since that visit:

“...And even in that visit once before you could see she was a patient with a medical history even without...all the background knowledge...but she had this extensive medical history”.

CK: “So what do you think took you back?”

“I don’t know, just a sort of intuition, a sort of gut feeling that something was just not right and I was very aware she had this chronic asthma and I did know that if she did do anything sort of untoward it would make her breathing much more laboured than normal and it just was a gut feeling I knew...because even after I left her I could not stop thinking

about her - there was just something not right...”.

In addition to her ‘gut feelings’, DN 7 clearly identified an extensive medical history and deteriorating condition of the patient.

The data suggests that in ill-structured assessment tasks, the DNs utilised problem solving approaches of cognition. This would suggest that experienced DNs do know what information they are looking for and the domains of knowing in the typology can be linked to the ways in which DNs make decisions. The stages of problem solving identified in current literature normally exclude the predecisional and feedback stages of decision-making identified by Carroll & Johnson (1990). In this study, these stages formed a vital part of the decision-making process and these stages are explored in the following Chapter.

CHAPTER SIX: DISTRICT NURSING ASSESSMENT IN ACTION

6.0. Introduction

The purpose of this Chapter is to present a case study which illustrates district nurse assessment. Analysis of this case is linked to the focus of the study - the assessment process, and to the main aim – the exploration of the relationship which exists between knowledge and decision-making in district nursing assessment. The assessment process is described and the way in which DN 3 applied her knowledge to the assessment and decision-making processes is analysed.

The stages of decision-making identified by Carroll and Johnson (1990) form a conceptual basis for the analysis of the decision-making processes of DN 3. These stages are linked to the model of district nurse assessment (Figure 2) distilled from the study data and described in Chapter 4. Knowing in practice is set within the context of the typology of district nursing knowledge described in Chapter 5.

6.1. Introducing DN 3

DN 3 was a caseload holder who worked with one other DN and a healthcare assistant. Patients registered with a range of General Practitioners were referred to the caseload and although DN 3 worked with a DN colleague, each had sole responsibility for their own caseload. The geographical area covered by DN 3 was a small market town and the surrounding rural community, with a population of approximately 11,000. DN 3 had worked in district nursing for 5 years at the time of the visit and first interview, and was educated to degree level.

6.2. Referral information and meeting George

The referral came from George's (the patient) son who said his dad 'needed help with a bath'. A referral had been made the previous week to the DN service but there had been some confusion and George had not been visited. DN 3 contacted the surgery prior to the visit for further information and this is discussed in greater depth below.

George's son answered the door and greeted us warmly. The DN had phoned prior to the visit to say when she was coming and had asked permission for the researcher to

accompany her. The patient was sitting on his chair in the living room. The DN introduced herself and the researcher and shook the patient's hand as she explained why she was there. She then got herself a chair and sat close to the patient whilst his son and the researcher sat close by.

6.3. Decision-making in action – visiting George

DN 3 made two significant decisions which resulted in action. Firstly, she decided to bath George at the visit and secondly she admitted him to her caseload for ongoing care. The decision to bath George at the visit arose from the assessment. The process of bathing contributed further to the assessment and was crucial to her ultimate decision-making and this will be explored in more detail.

Carroll and Johnson (1990) identified seven temporal stages of decision-making (Pg. 57) which provide a descriptive framework for the exploration of the decision-making processes of DN 3. The stages are:

- Recognition
- Formulation
- Alternative generation
- Information search
- Judgement or choice
- Action
- Feedback.

It is important to reiterate that this is not a sequential process but, rather, the stages may repeat and backtrack in a complex way as this following case will illustrate.

6.4. Predecisional activities

Two stages, *problem recognition* and *formulation*, are attributed to predecisional activity and involve the decision-maker in an initial exploration and classification of the situation. Here, predecisional activities were clearly identified by DN 3 who also demonstrated how she combined two further stages, *alternative generation* and *information search* with the preliminary stages of the decision-making processes.

The decision-making process begins with the *recognition* that there is a problem and therefore, a decision to be made. DN 3 had been asked to assess the patient for bathing so knew that meeting hygiene needs was a potential problem for the patient. As the DN and researcher travelled in the car to the visit, DN 3 said that as the patient's son had made the referral, she was wondering if the family were looking for help inconsistent with the wants or needs of the patient. She was already generating possible *alternatives* for action. DN 3 was clear in that she was going to undertake a general assessment, so recognised that she might uncover a number of problems which might or might not include bathing.

Having recognised the situation as one where a decision had to be made (this could be the decision that the patient does not need any help, or another solution could be found), the DN collected some available information about George prior to the visit. The DN telephoned the GPs surgery and in addition to gathering demographic details, she discovered that the patient had recently been discharged home from a local hospital following a CVA. She also knew from contacting the surgery that as he had high blood pressure, he was taking daily aspirin. DN 3 linked George's high blood pressure to the CVA he had suffered. She also surmised that as the patient was taking Zolvadex, he might have Carcinoma of the Prostate. On phoning the patient's home prior to the visit, she found out from the son that George had a poor memory and that was why the son wished to be there when the DN visited. DN 3 also knew that George had a daily home help as the son had told her when she telephoned him.

In this pre-decisional stage, DN 3 was *formulating* ideas about the situation she was about to encounter. Here she explains the ideas forming in her mind and how the information already uncovered at this stage would influence her search for further information:

“Well, the information I was given was quite limited obviously, I mean you can’t be told everything and you wouldn’t retain everything anybody told you anyway. But all I knew about this man was that he had had a stroke sometime within the last few weeks so it was going through my head “now has he got like a really dense hemi-paresis or is it quite mild” or you know “can the man communicate, can he speak...can he walk?” I was thinking all these kind of things. Also thinking about well there’s a Social Worker involved, I knew that...so thinking...has the Social Worker asked the occupational therapist to go in and see him, maybe different aids and adaptations to make his house better, you know, I knew that he had home care involvement. Is the home care going to be adequate? I had it in my mind that I was going to ask him how he was getting on, what his meals were like. I had it in my mind that I was going to look and see what state of kemptness he was in if you like, did he look like he was cared for, was he getting enough to eat, that kind of stuff, so I was thinking these kind of things”.

Already DN 3 was recognising and formulating a number of potential alternatives about George and his health, environment and about what he could and could not do.

The following extract identifies the search for information that DN 3 conducted as she approached George’s house. She linked her observations to her knowledge of the potential impact of CVA on mobility. If George’s mobility was affected then this could impact on his abilities to get out:

“...Going in I was just having a wee look to see if we were going up steps. I was thinking about access for the gentleman with his stroke. If he could get out and we did go up two steps. And I also noticed that it’s quite a bit from a car park so if the man needed transport he would have to walk quite a wee bit so I noticed that, now that I think of it...”.

Prior to meeting George, DN 3 knew he had suffered a CVA but did not know how badly this had affected his capacities to cope with daily living. She needed to collect information at the visit to clarify the true position. George’s son had made the referral to the DN and would be present at the visit. A Social Worker was also involved in this case. DN 3 did not know at this stage the nature or level of support offered by either party or indeed for what aspects of care George needed support. The intertwined processes already described (Chapter 4, Section 4.6) of needing to know certain information and identifying areas the DN does not know about, and needs to know more about are fundamental to the search by the DN for more information.

This case illustrates the complex processes involved in the predecisional phase of the decision-making process and can be related to the model of district nurse assessment distilled from the study data (Figure 2). Prior to meeting the patient, the DN was interpreting a range of information from written and verbal sources and from observation

of the context. At this stage, she did not know if the steps and distance from the car park were problematic for the patient but she was already constructing a picture and formulating ideas about the issues that might impact on George's life.

The predecisional stage of decision-making in district nursing practice appears to be a complex and essential part of the process. In addition to the information, the DN brings to the visit her prior knowledge and recognition processes, and the context of the visit will influence the assessment process (Bryans and McIntosh 1996).

6.5. Decision-making and problem solving

Carroll and Johnson (1990) describe the three stages of *alternative generation*, *information search* and *judgement or choice* as the 'common sense' view of decision-making. Alternative generation, which involves linking information search with hypotheses generation, allows the decision-maker to make a judgement or choice. These stages are equated with a problem solving approach or the hypothetico-deductive approach frequently employed by medical staff (Elstein and Bordage 1979).

Bryans and McIntosh (1996) suggest that the hypothetico-deductive model of decision-making utilised in the field of medicine may not always be appropriate to community nursing as many problems encountered by the DN do not have a clear end point. Many assessment tasks in community nursing practice present the DN with a range of alternatives as to how to meet patient's needs. For example, DN 3 mentioned to the patient at one point in the visit about using the Attendance Allowance he received to pay for a bathing service. However, she did not pursue this after the initial discussion with the patient or at interview. The hypothetico-deductive approach also fails to account for the predecisional activities illustrated above or for the action and feedback stages defined by Carroll and Johnson (1990) and described below (Bryans and McIntosh 1996).

The assessment task at this visit was to gather sufficient information in order to decide whether George needed help with a bath and the processes of alternative generation and information search were integrated. In this case there was potential for a tangible outcome of the visit - to provide assistance with bathing or not. In such circumstances it seems likely that the hypothetico-deductive approach to decision-making could account for part of the decision-making process of DN 3. Central to this approach are the processes of

generating alternative formulations of the problem (hypothesis generation) and cue interpretation – the process of interpreting the evidence in light of the hypothesis.

A possible explanation as to how the DN interpreted the presenting cues to form a judgement on which to base her ultimate decision can be found in the principles of ‘Social Judgement Theory’, developed by Ken Hammond and his colleagues and based on the work of Egon Brunswick (Hammond et al. 1980; Elstein and Bordage 1988). This theory considers how the decision maker combines and weights items of information known as cues in order to reach a judgement (Thomas et al. 1991). Brunswick’s lens model uses the analogy of a convex lens to illustrate the relationship between the judged state (diagnosis) and the actual state as mediated by a set of cues. The actual state may be thought of as something hidden from the judge and in order to reach a judgement, one must process the cues emerging from the situation in order to infer the true state of affairs. As the true state must be inferred, the relationship between the actual state and the emitted cues must be treated as probabilistic. Selection of the cues used by the judge will influence their overall judgement. It is possible that given the complex and ongoing nature of assessment, that different DNs might select and weight different items of information for the same patient.

Throughout the visit, DN 3 searched for information from the physical, social and contextual aspects of George’s life. Explicit cues such as the patient’s hearing aid, glasses and zimmer were noted and recognised by DN 3 in her search for information in relation to hearing, vision and mobility. Other areas pursued included appetite and arrangements for the preparation of food. Whilst asking George about his appetite and how he was able to prepare food, the DN asked the patient if he had heard of ‘meals on wheels’. George said he had, and following additional information that the DN had given him about the service he reaffirmed his decision that he did not want to consider this service. DN 3 detailed her information search and this example emphasises the impact of what she was sensing on her interpretation of the situation:

“... smell, you just can’t help but think “oh – is there a smell in here” and, you know, old man living alone - but there was no smell, the house was fine and I was looking and everything looked nice and clean. Em... it was warm and it’s a warm day anyway but he had his fire, he had access to his fire and he had his telly on so, and he had, well it’s difficult to say how happy he was, cause who knows who’s truly happy, but he seemed quite content there, his son was with him, he was relaxing, or looked like to be relaxing, he was watching the telly. Thought his chair looked a bit iffy, you know he was sitting on all those foamy cushions. I feel that looks a bit dodgy but perhaps that’s been explored, but...I will feed back to the Social Worker and ask him if he’s been in touch with the OT about

getting him a safer type (of) chair. So really just looking at the environment, saw the bathroom - the bathroom is well set up. I didn't look at the kitchen but his son assures us that he is close by and he's got a grandson who looks in every night so the man looked well nourished and all that so I didn't think the kitchen was a big issue".

This extract illustrates the number of cues utilised by DN 3 by sensory observation. During the visit, DN 3 thought that everything in the house was fine, it was warm and clean. The patient appeared to be well nourished and seemed to have good family support. Her overall judgement was that it was a comfortable home and "there was no great revelation" and that the patient was warm, well dressed and well nourished. In arriving at this judgement, DN 3 could have chosen to leave, comfortable in the knowledge George was managing. She chose an alternative course of action, however, - to bath the patient there and then. At first glance her decision to do so seems at odds with her assessment of the situation. There were a number of physical, social and contextual cues that contributed to this action:

Physical cues relating to patient

- Limited mobility of patient due to CVA (observed and confirmed)
- Patient was 89 years old (confirmed by patient and son)

Physical cues relating to carer

- Son had retired from work through ill-health (confirmed by son)

Psychosocial cues in relation to the patient

- Patient lived alone (confirmed at visit)
- Patient did not wish family members to assist him with bathing (confirmed by patient)

Psychosocial cues in relation to the carer

- Carer not comfortable about bathing his father (carer had contacted DN to ask for help)
- Family members did not live with patient (known) although they appeared to be very attentive (Grandson visited every day to give his grandfather a meal and attend to other household tasks, son visited regularly)

Contextual determinants

- The auxiliary nurse was on holiday, so a bath could not be arranged in the near future and George had already been out of hospital for almost two weeks – so it could be a month until he got a bath (known resource issue).

Another significant reason for bathing George at the visit was to see how he could cope with the physical task of getting in and out of bath. The *action* of carrying out the procedure confirmed for the DN that George was unable to get in and out of the bath unassisted. The DN also used this opportunity to check the condition of George's skin and issues relating to continence. DN 3 confirmed that George's skin was clear and intact but he had a slight difficulty with incontinence. She used this opportunity to discuss with George the provision of incontinence garments for the future. DN 3 was clear that it was not possible to assess a patient for bathing without determining how they were actually able to manage this task. By carrying out the procedure, the DN was able to obtain *feedback* on the true situation to inform her ultimate decision.

George was admitted to the caseload of DN 3 for fortnightly bathing. There were a number of reasons given for this decision:

Physical determinants of patient

- Patient could not manage in and out of bath himself (observed and confirmed)
- Ongoing supervision would allow nurses to note any deterioration in skin as the DN had discovered that the patient had a slight problem with incontinence

Anticipating future care needs

- Due to patient's age and medical history, the DN wanted to maintain contact in case future care needs arose. DN 3 intended to check from the patient's medical notes if her thoughts that the patient was being treated for Carcinoma of the Prostate were correct
- DN 3 thought that at a future date she might persuade George to go to the Day Centre. She did not think it was appropriate to pursue this at the first meeting
- The DN left the patient and carer details of how to contact her if necessary.

DN 3 employed the hypothetico-deductive approach to decision-making where she set out to confirm the need for a bath – the reason for referral. She weighted a number of cues from the physical, social and contextual aspects of George's life and judged that he was managing well with daily living. However, other information about his medical history, impaired mobility and social set up, led DN 3 to take further actions and she confirmed the decision to provide ongoing care by carrying out the task. It would appear that her decision to admit this patient to the caseload was rather more to do with anticipating what might happen in the future, than with the reality of the situation as she found it on that day at the visit:

CK "What do you think was the most significant thing in you offering him a continued service for bathing out of all the things that you have talked about so far?"

"Keeping a foot in the door I think, just making sure that if he deteriorates that we can help him, that we can get in there quick to help him. It might well be that he will improve cause it's very soon after his stroke and he has done very well in two months to be walking around almost independently".

There was also recognition that George had needs which could merit nursing care:

"...but I really do see him as a nursing need ... he has nursing problems, potentially could have skin problems...could potentially have mobility problems".

There was information that DN 3 decided not to pursue at the first meeting - her thoughts that George was being treated for Carcinoma of the Prostate. This resonates with the concept of the temporal unfolding of information where information becomes available and accumulates over time. George did not tell the DN that he was being treated for any condition other than his CVA and she did not ask. She was satisfied that she had assessed George adequately for the moment and made a decision which would allow for reassessment later for ongoing care and supervision of any deterioration in his health. DN 3 indicated that in the future she hoped the patient might agree to attend a local day centre as she thought this would improve his social wellbeing. DN 3 acknowledged that George was a quiet man, might not wish to go to the day centre and that her thoughts for his future care might not correspond with his.

6.6. Assessment in action

The main components of the assessment processes distilled from the study data (Figure 2 Pg. 157), are applied to the visit to George and the decision-making processes outlined above:

- Recognising salient features from the context
- Seeking information by use of senses and asking questions to confirm the need for intervention
- Interpreting information and formulating ideas on the basis of information collected
- Making connections and comparisons between the information collected and the context and formulating judgements
- Deciding to act or not to act

Recognising salient features from the context was a process evident in all stages of the decision-making process. DN 3 recognised that certain features from the external environment could impact on George if his mobility deteriorated due to the effects of the CVA. Throughout the visit the DN collected information from a range of sources. Some of this information was discarded quickly into the visit as the DN satisfied herself and decided that George's living conditions were conducive to daily living. The **salient features** which arose at the visit were:

- The safety and warmth of the environment
- The appropriateness of the physical environment
- The support available for the patient.

Seeking information through the combination of use of senses and asking questions resulted in DN 3 collecting a significant amount of information about George at the visit which lasted 50 minutes. The decision to assist him to bathe allowed DN 3 to extend the search for information and her knowledge of George by observing how he managed the activity of bathing. The key elements in the information search were:

- Observing the environment and physical condition of patient
- Asking the patient about his medical history and social support

- Assisting the patient to bath to determine how well he could manage.

In **interpreting information and formulating ideas** on the basis of information collected, the DN:

- Reasoned from the information collected, that there were no significant problems in relation to the physical environment
- Assessed that the patient had made good progress in the two months since the CVA although there was a degree of impairment to his mobility which restricted his abilities to bath himself.

In **making connections and comparisons** between the information collected and the context and formulating judgements the DN noted that:

- The environment in which the patient was living was adequate and no problems were identified
- The patient has some restricted mobility from the CVA which limited his ability to bath unassisted
- Due to the age of the patient and past medical history the patient might have future care needs.

In **the final decision to act or not to act**, the DN:

- Decided to admit the patient to caseload for ongoing monitoring and fortnightly bathing by the auxiliary.

The main components of the assessment process are illustrated below:

DN 3	Needs to know	Acquires information	Does not know but needs to know
Seeks information: asks questions to help identify salient issues	Needs to know about the impact of the CVA on the patient's activities of living	<p>Gains information about the patient's stay in hospital from the GP, patient and son</p> <p>Asks about hearing, vision, diet, mobility, social activities</p>	<p>If the patient can bath himself or needs help to bath or whether the family are requesting something that could be at odds with the wants and needs of patient</p> <p>If the patient is being treated for Ca. Prostate – did not pursue at first visit but was going to check medical notes</p>
Seeks information: uses senses, observes, to help identify salient issues	Needs to know if there are issues relating to continence, mobility, nutrition or environment?	<p>Observes that the patient's mobility has been affected by his CVA</p> <p>Observes that the environment was safe and warm and seemed appropriate and adequate</p> <p>Observes that the man appeared happy and content and well nourished</p>	Does not know if George can manage the physical process of bathing so decided to observe/assist him at the visit

Interprets and formulates ideas on the basis of information collected		<p>The patient looks well nourished and contented</p> <p>The man appeared to have good family support</p> <p>There was nothing in the physical environment that stood out as being potentially problematic</p>	<p>Does not know if the OT has been in contact with patient but thinks she should be as his chair looks unsafe</p>
Makes connections and comparisons between information collected and context: formulates judgements		<p>Estimates that with the combination of age, history of CVA and possible Carcinoma of prostate future health needs may arise</p> <p>DN bathed patient at visit and established he could not use bath aids unassisted</p>	
Makes decision to act		<p>Decides to admit to bathing service for visiting every two weeks</p>	

6.7. Knowing in district nursing practice

This case incorporates the elements of the typology constructed in Chapter 5. DN 3 approached her visit to George with a set of questions which were informed by her knowledge of the impact of a CVA and the recognition that the patient could be mildly or more seriously affected by this condition. She was seeking to build a picture from a broad base of questions. As the visit unfolded, she responded to the situation and linked what she saw with her search for information and subsequent actions and decisions. Collecting information involved moving from a broad base of questioning to a more focussed and direct search for evidence.

Getting to know George in his own setting involved understanding him as a person in his own environment. DN 3 collected information from the physical, social and contextual components of George's life. This allowed her to understand how the particular clinical situation of George was impacting on his daily living. Although George lived alone, his son was present at the visit and DN 3 was able to assess his role and that of other family members in George's life. There was recognition that the son was retired from work and had personal health problems. In this case, the family assumed the roles of co-workers as they took responsibility for some aspects of George's care such as preparing meals and shopping (Twigg and Atkin 1994). George indicated that he did not wish his family members to bath him and due to the son's own health problems it would have been difficult for him to do so.

Knowing what might happen in the future to George was based on the anticipation of future care needs due to his age and past medical history. This was a significant determinant in the decision-making of DN 3 as discussed above. She knew there were other areas she needed to know about in the future; for example, if she was correct that George was being treated for Cancer of the Prostate. However, as she was admitting him to the caseload there was no urgency about finding this out at the first meeting. This allowed the DN to pace her collection of information and future interventions. Knowing about the local day centre and the role and functions of the occupational therapist and social worker were specific knowledge of community based resources that related to George and his care.

6.8. Making the visit work

Throughout the interview, DN 3 emphasised the importance of establishing a good relationship with the patient based on mutual trust and support. Fundamental to this process was giving a good impression at the first visit:

“... you want to appear professional, you want to be able to identify yourself so people know who you are...like today, I phoned up before I went so the man knew I was coming, so that was good, he knew what time to expect me so he didn’t think who is this appearing on my door, so I think that is a good first impression to make ... to build a bit of trust and confidence in our service...”.

She goes on:

“I think it’s setting the scene...I think you can do an awful lot of damage or an awful lot of good on a first visit...trying to maintain this approachable appearance but also very aware that I am wearing the uniform of my profession and I really should be seen to behave and act in a certain way”.

When asked how she thought she did this, DN 3 responded:

“Well, I’m very conscious of calling him by his proper name. I would never ever go in and say, “well how’s it going George?” I think that can be quite demeaning and condescending to speak to someone who could be my grandfather in that way so I make a big effort never to do that and I always like to introduce myself to him although in this case his son was there I made a big conscious effort to make sure he was my focus, he was my patient, you know, rather than speaking through his son. And I shook his hand, cause I think that’s polite, and I brought my chair in so that I tried to make sure he could hear what I was saying and he knew that I was there for him but I didn’t want to make him feel threatened so I kept a wee distance from him, so really I was conscious of my body (language). Hopefully tried to use language he would understand, I tried to well, I tried to ascertain what his background was, that kind of thing, now he told me he was from the farm so that obviously makes you think in a certain way. I myself was brought up on a farm so that maybe helps a wee bit”.

CK: “Yeah....”

“So I wouldn’t need to start talking to him necessarily about the price of stocks and shares because I don’t think, well he may might be interested but the chances are that he is more interested in the price of wheat, you know that kind of thing so that’s really what I try to do, trying to gather as much non-verbally and verbally about the person to try and communicate with them as I see their level to be...but obviously again that is very subjective...”.

Observation of this visit by the researcher confirmed that the DN immediately established good rapport with George. DN 3 identified the influence of her own values on her actions when she highlighted it would be condescending to speak to the patient in a certain manner. Respecting the patient was an important indicator of values based knowledge. She was acutely aware of the impact of her non-verbal behaviour and as she stated, made a 'conscious' effort to ensure the patient was her focus. She acknowledged that because the patient's son was present there could be a temptation for the patient, son or DN to talk through one of the other parties rather than a one-to-one basis. Knowing how to communicate with George in his own home was a significant part of the assessment process.

During the visit, the researcher observed the patient frequently looking at his son when the DN asked for information. However, the patient, a quiet man of few words, did respond clearly and in a relaxed manner directly to the DN. The DN's background gave her an area in common with George and she used this as a friendly type of approach by talking in general terms about her upbringing and asking him about his working life on the farm.

DN 3 displayed sophisticated interpersonal skills throughout the visit, not only in her tactful actions as demonstrated above, but also in her understanding of how the patient might feel if certain areas of his life were explored in the presence of others. During the visit DN 3 took George to the bathroom and helped him to bath. At the interview following the visit she identified two areas that she considered needed tactful handling. The first area, continence, she did explore at the visit but in the privacy of the bathroom:

(Giving George a bath at the visit) "...gave me a chance to explore his continence issues in relative privacy because he might not have wanted to discuss that in front of his family no matter how close. And when I was in there actually I did realise that he was wearing a pad and wee net pants...he knows now that if he needs more pads I'll get them for him...So that was a good thing that we couldn't have probably explored in the living room very easily, I mean it's not easy to bring these kind of issues up. I mean everybody pays lip service to...you know, and how are your bowels... and all this kind of stuff but how many people would realistically want to answer that in a room full of four people?"

DN 3 also explored a range of other issues in the privacy of the bathroom and identified areas she would not seek information about:

"...when we were in the bathroom as well, I was asking about how long he had been a widower and it had been twelve years – and what had happened to his wife – she had a stroke and had died on her holiday in Glasgow, he hadn't been there and we talked, I really

didn't explore his sexuality in any way but to be realistic I don't know how much exploration I would give that anyway and rightly or wrongly I don't pay a lot of attention to that unless the patient volunteers that. No but I mean, no I don't think there was anything, I felt quite relaxed with George. I felt we hit it off quite well and we, well the man is forgetful and quite emotional but I think we got on OK".

The DN immediately established a good rapport with George and his son who were quiet, undemanding men of few words. The DN searched for information throughout the visit and led the agenda for the visit. As the patient and son only volunteered information when asked this was an appropriate approach and there was no sense that the patient or son were uncomfortable at any stage of the visit.

6.9. Discussion

Exploration of this case provides a wealth of detail about the complexity of the assessment process in district nursing practice. Although it is not possible to generalise from this case, it does provide insight to the intimate connections between decision-making and knowledge in first assessment visits in district nursing practice.

The concepts of bounded or limited rationality have been reported in cognitive psychology for over 30 years and these acknowledge that the human mind is limited in attention, memory and calculation (Newell and Simon 1972; Carroll and Johnson 1990). This means that we cannot work out all the information we need or fully understand information collected, in a short time (Elstein and Bordage 1988). This concurs with the view of assessment as an ongoing process and acknowledges the limitations within decision-making of the processes of information searching and interpretation at the first meeting. The case study demonstrates that DN 3 was selective about which aspects of George's situation she pursued at the first meeting. For example, she decided not to ask George directly if he was being treated for Cancer of the Prostate. Similarly, although she thought that in future George may benefit from going to a Day Centre, DN 3 did not raise this possibility at the first visit. DN 3 preferred to wait until she had built a bigger picture of George's situation and established a relationship with him. Pacing the collection of information is therefore a useful strategy for DN practice where visits may be lengthy and tiring for patients and where the relationship with the patient often extends over a long period of time.

Literature identifies the concepts of bounded rationality and the temporal unfolding of information (recognition that all information needed to make a judgement might not be available at the first meeting) as separate entities. This study has exposed possible links between these concepts. The case study has revealed that DNs may use pre-encounter data from referral and community related sources to focus their information search. Additionally, they utilised knowledge derived from a number of other sources including the powerful contribution of sensory data. The DN, therefore, limited the scope of her information search in the recognition that all the necessary information could not be available at the first visit and thus aimed to prevent data overload.

The case study reveals important information about the range and use in practice of cues by the DN in discerning the patient's needs and arriving at care decisions. DN 3 derived knowledge from sight, sound, smell and touch and drew on verbal and non-verbal cues to inform her judgement about how George was managing. For example, she identified that the environment was warm and clean and also surmised that George was happy and supported (Pg. 207/8). DN 3 was able to identify the cues that informed her actions and link these to her overall goal: to ascertain whether the patient needed help with bathing. DN 3 also linked the cues to other aspects of nursing knowledge. For example, she appeared to recognise the links between poor living conditions and health, the importance of heat and warmth to an older person with restricted mobility and the importance of appropriate family support to wellbeing. This finding illuminates the potential overlap between practice-based and theoretical-based knowledge. It reinforces the suggested value of, and need for DN students to learn about assessment and about the relationship between knowledge and decision-making, by focusing on real life examples.

This case also demonstrates movement between inductive and deductive modes of cognition and decision-making as a strategy for coping with complex problems. Some aspects of the patient's life were more visible and tangible than others, so this finding is both realistic and significant. Recognition that the DN has to make some decisions before leaving the home of the patient provided the impetus for her to collect and interpret whatever information was available to help her. DN 3 incorporated the two main decision outcomes of the assessment visit identified by the study in her decision-making. She assessed with certainty that her patient needed a bath and therefore this decision resulted in on-the-spot action and an objective end-point. Other aspects of George's care were less predictable and therefore a temporal evaluation of his anticipated future healthcare needs

was made. This finding supports the assertion that DNs may employ different decision-making strategies in order to reach an overall evaluation of the patient's situation. DN 3 was able to recall in some detail her reasoning, as she collected information from the patient and his environment.

Gathering knowledge about, analysing and understanding the context in which the patient's problem existed, was crucial to the decision-making process. Pattern recognition, the process of making a judgement on the basis of a few critical pieces of information (Benner and Tanner 1987), is a useful strategy for relatively straightforward aspects of the decision-making process. The process of pattern recognition is one in which the decision-maker compares patterns of the patient's problems (and situation) with those of patients previously seen.

Barrows and Feltovich (1987) argue that pattern recognition trivialises the decision-making processes of doctors and cannot account for the impact on decision-making of data which are ambiguous or unfold over a period of time. This criticism may relate to the requirement for doctors to make a diagnosis quickly, albeit a provisional one. This study has demonstrated that often the first assessment results in a temporal evaluation of the patient's overall situation rather than an overall agreed end-point (or both as in this case), and therefore pattern recognition might account for some of the decision-making processes utilised by the DNs.

The study also demonstrates that pattern recognition in DN practice is likely to comprise a complex knowledge base derived from both practical and theoretical learning. For example, deciding that a wound is healing without complication is likely to be informed by an amalgam of practical experience gained from similar visits with theoretical knowledge of the factors influencing wound healing. Similarly, decisions about levels of nursing support for a patient who has suffered a CVA will be informed by experience of rehabilitation trajectories and knowledge of vascular and neuromuscular damage and healing. This study suggests that pattern recognition within DN practice would be a fruitful area for further enquiry.

The hypothetico-deductive approach to decision-making can account for part of the decision-making processes in George's case where DN 3 started with the prediction that George would require help with a bath. However, the DN was aware of a number of

possible end-points. Possible end-points could have been that George could manage himself with or without bath aids, his family could assist, the Attendance Allowance could be used to pay someone else to provide this service or the patient could attend the Day Centre where he could be bathed. DN 3 had to generate the possibilities and weight cues from the presenting situation to inform her decision. The linked processes of action and feedback utilised in this case are often excluded from descriptions of problem solving such as the nursing process or the hypothetico-deductive approach to decision-making and should be recognised.

Achieving a balance between certainty and uncertainty is a crucial component of assessment practice and fundamental to the search for information. It was suggested above that current nurse education focuses on training nurses to solve problems and that the adoption of systematic problem solving approaches would help in this endeavour. However, this case demonstrates that identifying problems with certainty in all aspects of the patient's care was not possible or indeed desirable. DN 3 could predict with some certainty that George needed help with the physical process of bathing. She confirmed this by carrying out the process with him. However, anticipating his future prognosis and resulting healthcare needs was less certain. She judged that certain events might unfold and part of her decision-making was based on this premise. Decision-making was staged and temporal.

The anticipation of George's future care needs was based on her knowledge of post CVA rehabilitation and on the likelihood and potential impact of a further CVA on George. The ability to anticipate future care needs suggests a complex knowledge base derived from previous experience, theoretical knowledge and the personal values of the nurse. This finding supports suggestions that experts have an elaborate knowledge base to draw from and the ability to encode and chunk information from past experiences to inform current actions. This involves direct automatic retrieval from well-structured networks of stored knowledge (Groen & Patel 1985). DN 3 recognised the importance of the situational aspects of George's life when she made the judgement that he was managing satisfactorily but also recognised that he was at increased risk of suffering another CVA.

Acknowledging uncertainty in clinical practice is vital to the process of uncovering practice based knowledge. Anticipating what may happen is a legitimate element of practice based knowledge which needs further exploration. Anticipation as a strategy for

assessment practice can also be linked to the concepts of bounded rationality, which acknowledges the limitations that exist to the human capacity for rational thoughts. Problem solvers require to process and select data in a way that allows them to represent a clinical problem in a simplified way in order to provide some initial formulations (Elstein and Bordage 1988). The case study has demonstrated that the DN identified a range of cues but chose not to use some of the information gained. For example, DN 3 did not pursue why the patient was taking Zolvadex, preferring to wait until a future visit to broach this subject. Ability to discriminate between cues and select those which are important to pursue at the initial visit, is an important characteristic of skilled DN assessment.

This case reflects the six patterns of knowing described in the typology and illustrates the complexity and breadth of the knowledge base contained within each pattern. The blending of 'knowing that' (theoretical knowledge) with 'knowing how' (practical knowledge) combined with the values based aspects of DN practice demonstrated in action, provide some insight into the knowledge and decision-making of DNs.

The typology proposed, that in order to understand how the patient was responding to their particular clinical situation, the DN had to get to know the patient and carer as people. This suggests that a broad based education that includes both life and social sciences is essential for community nursing practice (Reed and Proctor 1993; Murphy and Atkins 1994). Knowing how to embark on and establish a relationship with patients and carers was attributed by the DNs to experience.

The other patterns identified in the typology; knowing what needs to be done now; knowing what might happen in the future; knowing what are obvious knowledge deficits and knowing the community resources and services, suggest a significant experiential component. The DNs had learned to recognise that certain events were likely to unfold given a particular set of circumstances. This is not to suggest that these patterns of knowing do not contain scientific or theoretical knowing but, rather, that these forms of knowing are integral to the 'knowing how' of DN assessment.

This case study illuminates assessment knowledge in action. The combination of observation and interviews as research methods allowed access to DN 3's understanding of the situation she encountered, and rationales for decision-making. The findings therefore provide new insights into the connections between community nursing assessment

knowledge and decision-making and into the reciprocity between theoretical and practical knowledge.

CHAPTER SEVEN: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

7.0. Introduction

The main focus of this concluding Chapter is the discussion of the findings from the study. The extent to which the aims and objectives of the study have been met is considered through the evaluation of the strengths and limitations of the research approaches adopted. The implications of the findings for further research, practice and education are drawn and recommendations are given in the final section of this thesis.

The researcher came to this study with experience as a DN and as a teacher of DN students. The research approach adopted was based on the premise that it was important to examine the everyday, often taken for granted, work of DNs in relation to first assessment visits. The overall aim of this study was to uncover the knowledge held by DNs and to analyse how they used this knowledge in their decision-making and practice in relation to first assessment visits.

Several important insights for district nursing assessment practice have been gained. These relate to the knowledge base of the DNs, the way in which this knowledge is applied to assessment practice, the processes involved in district nurse assessment and the ways in which DNs make decisions. The discussion of these insights is set within the context of the objectives of the study.

7.1. 'Knowing how' in district nursing practice:

The first objective of the study was to describe the knowledge in action of DNs undertaking first assessment visits. The findings provided an in-depth description and interpretation (Chapters 4 and 5) of the process of assessment and practice based knowledge used by the DNs in assessment. The most striking findings relate to the influence of the context in which the DN/patient interaction takes place and the reflexive character of the assessment process. The knowledge required for district nursing assessment practice comprised (theoretical knowledge) 'knowing that' **and** (practical knowledge) 'knowing how'.

The findings of this study support the work of Macleod (1996) and Luker and Kenrick (1992) who suggest that the theoretical knowledge of experienced nurses becomes embedded in the practice context. The theoretical knowledge held by nurses becomes part

of ‘knowing in practice’ and is described in relation to the context in which this knowledge is developed and used (For definition of context, see Chapter 4, Section 4.0).

This approach of describing and making evident knowledge-in-context, differs significantly from that of some authors reviewed in Chapter 2. This included Carper (1978), Chinn and Jacobs (1987), White (1995) and Rolfe (1998) who sought to describe knowledge by differentiating between scientific, aesthetic, moral, personal and experiential knowledge. Benner (1984) described practical knowledge in a different way by identifying competencies in practice and classifying these into 7 domains. This description resulted in a different taxonomic form to the authors identified above but still removed knowledge from the context in which it is developed and used.

As discussed in Chapter 5, it was not possible or desirable to explore the knowledge in action demonstrated by the study participants by removing it from the context in which it occurred. As such, the findings challenge the utility of existing theoretical models in helping practitioners to understand and develop every day practice. This not to underestimate the value of existing theoretical frameworks in identifying that knowledge in nursing practice is derived from a range of sources. However, it seems important to focus on uncovering and illuminating knowledge in use rather than continue to classify knowledge as distinct categories.

The literature review identified that intuition, as a feature of expert nursing ‘know how’, is considered to be unique to the individual and knowledge that cannot easily be uncovered or shared with others (Benner 1984). It was also argued that DN assessment was likely to comprise large areas of implicit and unrecognised knowledge which might be discovered using a naturalistic approach to data collection and analysis. The combination of observation and interviews and an interpretive approach to data analysis appear to have revealed such knowledge. The study findings reveal practical, theoretical and values based knowledge which relate to how the DN manages the assessment visit.

7.1.1. Influence of the context on the assessment process

The study revealed that a breadth of information was required for assessment and the way in which the DNs used their knowledge at the assessment visits related to the situation of the patient due to illness, and the context in which the patient lived. The DNs utilised a

range of cues to inform the assessment process and as a method of prioritising patient needs. The importance placed on assessing the psychosocial needs of the patients and/or carers was striking throughout. The DNs were influenced by several psychosocial issues including the presence or not of other family members and the social conditions which prevailed. The work of Bryans (1998) also suggests that DNs rely on a significant number of psychosocial cues in assessment. This finding challenges the reported perceptions of other healthcare professionals including GPs and social workers, that DNs work within a narrow frame of reference (Worth et al. 1995).

A second objective of the study was to identify and classify the basis of decision-making by the DNs. The analysis of data revealed that gathering information, prioritising tasks and decision-making strategies were linked to the nature and type of the assessment task (certain/uncertain, straightforward/complex) and the prevailing psychosocial conditions. In straightforward assessment tasks such as uncomplicated wounds, less information was required and the visit was more likely to result in clear decision-making. Where the assessment task was more complex, additional information was required as patients could have a number of needs and the DNs therefore had to prioritise their actions. The DNs had to identify whether or not the patient was managing. This was termed deciding on 'the main thing'. The DNs used deductive **and** inductive approaches to decision-making (Crow et al 1995) and the cognitive skills of problem solving and pattern recognition (Goen and Patel 1985) were identified.

Given the interest in intuition as a basis for professional practice (Benner 1984), it is significant that with one exception, the DNs in this study did not refer to decision-making as being based on 'gut feelings' or 'hunches'. The study demonstrated that practitioners **could** unpack and describe their knowledge and decision-making, a process facilitated by centring on real life examples/cases. As discussed (Chapter 5, Section 5.3.1) although DN 7 identified such feelings, she was able to offer a rationale for her actions. This finding bears resemblance to the assertions of Easen and Wilcockson (1996), who suggest that decision-making, as a rapid process, can be validated as it is based on a sound, rational knowledge base, applied to situations which have become familiar through experience. However, questions remain as to how the quality of decision-making can be evaluated. Research methods, which include evaluating outcomes of decision-making and subsequent actions from the patient's perspective, need to be employed.

The third objective of the study was to make explicit the relationship between the knowledge base of the DN and her decision-making practice. The case study presented in Chapter 6 aimed to illuminate the intricate links between knowledge and decision-making. In depth exploration of this case revealed the potential links between the mode of cognition used by the DN and the assessment task (Hammond 1988). The case study also revealed that rather than arrive at a clear-cut decision, the first assessment often results in the DN making a temporary evaluation of the patient's overall situation. Bryan's (1998) findings support the evaluative features of assessment as her findings also suggest that DN assessment may result in an evaluation of the patient's needs rather than clear-cut decision-making.

This study further revealed that DNs require particular knowledge in relation to the local community and the resources available to assist in meeting patient needs. This knowledge was particular to the local area in which each DN worked and was important to the needs planning process, and influential in decision-making.

A related finding was the infrequent use of the term 'need/s', a term frequently cited in current policy and literature, but rarely used by the DNs in this study. They talked about deciding whether a patient and/or carer were 'managing', which alludes to an evaluation of the overall situation. Worth (1999) found that the DNs in her study had limited appreciation of the changes outlined in health care policy which emphasises the role of the DN in needs, rather than service led, assessment.

7.1.2 Reflexive character of first assessment practice in district nursing

The reflexive character of assessment in district nursing practice revealed by the study is illuminating for DN practice. In some cases, the actual situation did not relate to the reason for referral and the DN had to establish if there were identifiable needs with which she could assist. Although the referral task was normally central to the visit, how each DN approached the first visit related to the situation and conditions prevailing at the time. For example, the DNs were **attuned** to the physical environment and issues such as smell, heat and safety. They also understood the moods, feelings and atmosphere in the home and **responded** to the current situation. Being attuned to the salient issues, and the ability to respond, characterise the reflexive nature of DN assessment practice.

It is noteworthy that the limited information normally provided at the time of referral to the DN service was not necessarily problematic for the DNs. The participants in this study viewed assessment as an ongoing process involving the gathering of information about the physical and psychosocial status of the patient and family. Therefore, part of the assessment process was to determine what information was needed in a given situation to predict what issues were important at home.

Building the bigger picture was important to the DNs who drew information from the physical and psychosocial aspects of the patient's situation. In order to avoid the visit becoming an interrogation, the DNs paced their collection of information – so tension existed between what information **could be** and **should be** collected at the first meeting. The DNs appeared to have learned how to make such a distinction through experience.

A study of DN practice (Audit Commission 1999) in England and Wales was critical of the quality of many assessment visits carried out by DNs. Some aspects of this report may be relevant to the Scottish context. The study used a range of data collection methods including group and individual interviews, surveys and documentary analysis. However, observation of DNs at work was not included in the study methods. Continence assessment was highlighted by the Audit Commission report as an area where variations in assessment quality were apparent. Analysis of patient documentation revealed that key parts of continence assessment were often missing. In this current study, DN 9 visited a patient to assess continence (Pg. 168). However, she did not carry out a full continence assessment which could be matched to the recommended practice guidelines outlined by the Audit Commission (1999 Pg.49). DN 9 judged that there was little evidence, from the environment in which the patient lived or from the patient's responses to questions, that she was incontinent. The DN did not want to upset and offend the patient so decided not to confront the patient by pursuing issues such as descriptions of urinary symptoms or information about frequency/volume. In this case, documentary analysis alone would reveal that some of the information required for continence assessment was missing. However, observation of the visit by the researcher confirmed that the patient might have been offended if the DN had pursued the issue. Additionally, the DN provided a rationale to support her actions and decision-making immediately after the visit at the follow-up interview.

This current study demonstrates that collecting information is a paced process determined by the prevailing situation and practitioners are selective about which aspects of the patient's situation they explore at the first visit. Bryans (1998) also identified in her study of DN assessment practice that practitioners were selective about the recognition and use of cues.

For instance, in this current study some visits were more focussed on physical aspects of needs and the DN participants identified that the exploration of certain areas at the first visit was considered to be 'beyond the boundaries'. Establishing a relationship was perceived to be crucial before information relating to some lifestyle, social and psychological issues could be pursued. Given the reflexive and context driven nature of the assessment process demonstrated by this study it seems important to focus on real examples in future studies of DN practice.

There exists no one agreed framework for DN assessment and the complex and multifaceted situations which the DN might encounter when visiting patients at home suggest that the use of a rigid framework for assessment, such as that provided by nursing models, may be inappropriate. However, practitioners need to explore the utility of theoretical frameworks to guide their practice and be encouraged to reflect on their practice. Given the opportunity, the participants in this study were able to provide rationales for decision-making. However, determining whether different DNs would have arrived at similar decisions in the same case, was not explored.

A key feature of 'knowing how' in district nursing assessment practice related to the strategies adopted by the DNs to make the visit work and on information collection and analysis as a paced activity. The emphasis placed on the necessity to form a good relationship with the patient and family was striking. Apart from the completion of necessary tasks, the first visit was viewed as essentially a 'getting to know' experience and the DNs highlighted a number of strategies for making the visit work. Being able to give the right impression, establish trust and rapport and use friendly strategies was mainly learned through experience, and seemed to link to the values of the DN. Bryans (1998) identified patient assessment as an inherently social process and the findings from the current study would support this claim. Assessment knowledge in use and decision-making were characterised by the way the DN linked what she was **seeing**, **asking** and **doing** at the assessment visit.

In addition to the identification of present care needs, the ability to anticipate future care needs of the patient and the anticipated illness trajectory formed an important part of the care planning process. This finding suggests that for some components of their role, the DN assumed a proactive approach to needs assessment.

In summary, the study findings reveal that assessment in district nursing practice is complex and reflexive in nature. The model for district nursing assessment (Figure 2) has been constructed to capture the reflexive and context driven nature of the process. The components of the model can be relevant and evident in a first assessment visit.

7.2. Review of research approach

The research approach undertaken in this study lay within the interpretative tradition which seeks to understand meanings from the perspective of the study participants. In this study, the meaning of first assessment visits in relation to knowledge and decision making was explored from the DN's perspective. Qualitative methods were used to gather data, allowing the participants to both demonstrate and describe their practice. Additionally, in qualitative research, the researcher is influential at all stages of the study (Lincoln and Guba 1985; Hammersley and Atkinson 1995). Observation allowed the researcher to draw upon her own experience as a DN in order to develop and extend understanding of the work of district nurses in relation to first assessment visits.

The following section evaluates the utility of the overall research approach adopted for the study. The extent to which the approaches to data collection and analysis facilitated achievement of the aims of the study will be considered.

7.2.1. Field work - The approach to observation

The focus of the study was the DN in the context of her assessment practice. Participant observation, as one of the main methods of data collection in ethnographic research (Hammersley 1998), proved to be useful in describing and interpreting DN assessment practice and uncovering knowledge embedded in practices.

Observation of the DN/patient interaction contributed to the findings presented in this study in two significant ways. Firstly, it was possible to discern the potential impact of the

environment on the actions of the DN. The number and range of observational cues utilised by the DNs, whether the patient was likely to require ongoing care or not, were important. This helped to illuminate the tensions existing between gathering enough information on which to base the assessment and avoiding the visit becoming an interrogation. Secondly, it also identified how the DNs used information gained from available cues to identify and prioritise needs.

In addition, at the in-depth interview which followed the observation of the visit, the researcher was able to ask questions which were directly related to the patient. This may have enhanced the depth and clarity with which some of the participants were able to articulate their thoughts and judgements. This view was supported by the DN participants at the feedback session who said that talking through what they had done and why, had helped them to better understand their own practice (Section 7.2.7).

Achieving informed consent during periods of observation presents particular challenges to the researcher. The steps taken to ensure that the DNs and patients gave informed consent have been described in Section 3.11.1. It is important to emphasise the specific difficulties in ethnographic research of ensuring that study participants confer ongoing informed consent. Even where it has been clearly stated that research is taking place, as in this study, participants are likely to forget that data are being collected during a health care visit (Hammersley and Atkinson 1995). Ensuring ongoing consent from the DNs and patients has to be balanced with minimising the disruptive effect of the researcher. Continually reminding participants that research is taking place is potentially disruptive. In this study, verbal permission was sought from the patient at the start of the visit. Written consent was then gained when the DN had finished the visit. Therefore, the patient was reminded at the end of the visit about the research, when any anxiety they may have had in anticipation of the visit was likely to be reduced. However, tiredness at the end of a lengthy visit or relief that the visit was over might reduce the likelihood of patients asking a researcher for further information. Additionally, written information was left in each house inviting the patient or a family member to contact the researcher or named supervisor for further information (Appendix 7 & 9). However, it is not possible to tell participants everything that is being studied in ethnographic research as the significance of data may not be apparent until systematic analysis has taken place. Therefore, it could be argued that achieving 'true' informed consent is difficult and perhaps impossible.

Using observation as a research approach requires the researcher to acknowledge the potential for bias that exists. In Chapter 3 (Section 3.9) the way in which observation was approached in this study was described. As the researcher in this study was an experienced DN, the framework for recording the field notes was developed to focus the observations towards the aims of the study, thereby reducing the potential for bias. In addition, genuine efforts were made to maintain open and broad interpretations of the interaction being observed.

Experience as a DN for 13 years and familiarity with first assessment visits clearly impacted positively on the process of observing practice. However, it is acknowledged that the researcher may have missed some of the tacit knowledge embedded in practice by failing to note or by dismissing everyday practice which was very familiar to her. However, it is proposed that the study does illuminate important tacit knowledge. For example, ‘making the visit work’ (Section 4.2) provides a description of the embedded practices of the DN participants. Despite many years experience as a DN, the researcher had not previously identified the existence of such practice-based knowledge.

Particular efforts were made to ensure that the researcher captured as much information as possible and the framework developed for observation and field notes proved useful (Section 3.9). Observation visits carried out in the exploratory stages of the study, when the framework for recording field notes was developed, reassured the researcher that significant amounts of information could be captured. The interaction between the DN and her patient included the carrying out of particular tasks and therefore natural gaps for note taking occurred. For example, during the process of dressing wounds the DN may only have asked intermittent questions. Similarly, looking at medications, reading letters or moving to other parts of the home provided natural gaps which allowed the researcher to capture a significant amount of detail.

It is acknowledged that the interpretation of the visits could be biased towards the views of the researcher. However, it is proposed that the approaches to the interviews (Section 7.2.2), the substantial use of the participants’ views (Chapters 4, 5 and 6) and the efforts made to ensure the trustworthiness of the findings (Chapter 3, Section 3.15 and Section 7.2.7) enhance the credibility of the findings.

7.2.2. The interview approach

Each participant was interviewed twice and although both interviews were semi-structured, the second interview was more focussed to allow the further exploration of the themes which emerged from the first interview. The questions were mainly open and the researcher endeavoured to pursue relevant areas identified by the DN during the interviews.

Throughout the interviews, the DNs appeared relaxed and open with the researcher. Prior to the start of the study the researcher knew most of the DNs and this might have caused them to appear relaxed. The approach adopted for the interviews resulted in the rich data used to construct the narrative accounts in Chapters 4, 5 and 6. In ethnographic research it is important that the reader can grasp a ‘picture’ of that being described (Hammersley 1998). It was the intention of the researcher to construct an account grounded in the perceptions of the participants and balanced with an appropriate interpretation of the issues arising.

7.2.3. Selection issues

The reliance in this study on participant observation as a research method complicated the selection process. It was difficult to match available first assessment visits with a part-time researcher’s available time. The 12 assessment visits, which formed the basis of this study, were drawn from those available using convenience sampling. Recognition is given that the study has explored a restricted range of DN assessment visits. However, commonly occurring types of DN visits were observed and a balance was achieved between straightforward and complex assessment visits (Table 1).

7.2.4. Approach to analysis – interpreting the field notes and interviews

The analytic processes used within the study sought to reflect both the ongoing nature of analysis and the interpretative relationship required with the data in ethnographic analysis (Hammersley 1998).

Data analysis began at the point of first meeting the DN and continued as the visits were observed and the interview data collected. As the analysis progressed, the researcher

increasingly gained new insights to DN practice and developed enhanced interpretative skills. The complex nature of the knowledge base being described and the processes involved in DN assessment became more evident as analysis progressed. Throughout the analysis process, the researcher referred to theory and literature in areas relating to the emerging themes (Section 7.3) in order to enhance understanding and interpretation.

A major challenge was finding ways to preserve a sense of the ‘whole’ whilst analysing the data. Listening repeatedly to taped interviews, writing extensive field notes, code notes and story lines for each DN enhanced the processes of interpretation adopted. The researcher also kept a reflective diary and recorded emerging thoughts and questions arising from the data and the analysis process. The following questions were central to the analytical process:

What is the nature of the knowledge being demonstrated/used in this situation?

What do these data tell me about the assessment process?

What factors seem to be influencing the decision-making of the DNs?

How does this particular issue relate to the issues uncovered so far?

This approach to analysis allowed the researcher to construct a picture of the practice of the study participants and to determine patterns that were emerging across the data. The interpretation presented in this thesis was developed through several written drafts and this drafting process contributed to clarification of concepts. Throughout, the three supervisors were involved in the discussion and refinement of the themes and categories presented in this thesis. In addition, each DN participant and the nurse manager who supported the study were given a summary of the findings and invited to provide comments on the issues presented (Section 7.2.7).

7.2.5. Advantages of research approach:

The practice focus of the study, with opportunities to gather data directly from the field of DN work was a particular advantage of the approach adopted. The visit gave the researcher and DN participants a clear focus for the exploration of assessment practice. This approach facilitated the in-depth description of a range of DN assessment visits/tasks and it made possible identification of a breadth of knowledge in use.

The research approach sought to achieve depth of understanding from a small number of cases rather than generalisable findings from a large number of cases. Each DN was interviewed twice and, in addition to the field notes from the observation of the visit, this resulted in significant amounts of data for each DN. The opportunity to explore further emerging themes at the second interviews, added to the depth of interpretation possible in the study.

Participant observation also revealed important information about the nature and range of cues utilised by DNs. This finding was crucial to the description of the influence of the context and the reflexivity of the assessment visit and could not have been captured from interview alone.

The ethnographic approach requires the researcher to balance involvement in the research with the search for objectivity. From a personal stance, a particular advantage of the research approach for the study was the opportunity to become absorbed in a reflexive process which drew on past experience as a DN, experience as a teacher and experience as a researcher which was gained as the study progressed. Balancing each perspective was challenging and required the researcher to reflect on and analyse emerging issues at a depth greater than in any previous activity undertaken. In the field, the researcher was comfortable with the DN role and visiting patients at home. The recognition that some data may have been missed has been discussed above. Experience as a teacher and facilitating student discussions helped the researcher to explore issues in depth at interview with the DNs.

There exists debate about the role of the practitioner as researcher. It has been suggested that:

“Practitioner knowledge informs research by guiding choice about research questions and research strategies, and a clearer understanding of what practitioner knowledge is (or more accurately, what people have thought that it is) is a useful starting point” (Meerabeau 1995 Pg. 32)

Experience in the field may therefore guide the research from the beginning. Knowing what questions to ask is crucial to the exploration of practice based knowledge which has been described as ‘messy’ and complex (Schön 1991). Additionally, practitioners may find it difficult to articulate knowledge which has become deeply embedded in everyday

practice (Rolfe 1998). Where a researcher is exploring an area of practice with which they are very familiar it is essential that they do so from the perspective of an outsider. Moving between the 'insider' and 'outsider' roles in the research process is challenging.

The researcher in this study, although an experienced DN had not, at the beginning of the study, worked full time in DN practice for 5 years although links had been maintained with practice. At the time of writing, the researcher had not been involved in day to day practice for 10 years. Therefore, the researcher had background knowledge but no recent day to day experience. This may have enhanced the objectivity of the interpretation presented in this thesis. Experience as a teacher and researcher has resulted in additional interpersonal and analytical skills, not possessed as a practitioner 10 years ago.

The contribution of study to decision making research

The exploration of decision making in practice is challenging. In this study, the combination of observation with interviews proved to be the key to unpacking and illuminating the knowledge and decision making of the DNs and some progress has been made towards understanding the relationship between these two concepts. Having a visual image of practice scenarios supported by field notes, allows a researcher during interviews to ask questions, probe and share moments from practice in ways that move enquiry meaningfully forward. The depth of interpretation achieved in this study would not have been possible if self-report methods, such as interviews, had been used alone. Simulation can be used in decision-making research and whilst this method can be highly productive (Bryans 1998), the quality and realism of the situation is crucial, as respondents may act differently if the simulated situation does not appear to be 'real'. Similarly, talk aloud methods may be liable to hindsight bias (Thomas et al 1991). As this study was based in practice, the findings relate to the reality of DN work.

Observation and interviews are therefore recommended as useful methods in decision-making research with nurses in practice. It was of interest that some DNs were aware of gaining insights over the study period into previously unnoticed aspects of their practice. Longer periods, with repeated observation and serial interviews might allow experienced professionals to further analyse their knowledge base and articulate in more depth its relationship to day-to-day decisions. For this to happen, two things would be essential:

careful analysis of the logistics and ethics of gathering data with practitioners in the field and mutual trust and respect between researcher and practitioner.

7.2.6. Limitations of research approach

A number of limitations therefore need to be acknowledged in a study of this nature. Firstly, placing the focus on the exploration of the first assessment visit only was limiting, as it was evident from the DN's accounts that assessment could be an ongoing process, undertaken at each patient encounter over varying periods of time. It was only possible to explore how the DNs approached and paced their search for information in relation to the first visit.

Secondly, as only one visit was undertaken with each DN it was not possible to identify if the individual participants would have reacted in similar ways at different visits. This limitation may have resulted in an underestimation of the knowledge base of the DNs, as different visits might have required different skills. Also, it was not desirable or possible for the researcher to evaluate the quality of assessment/decision-making. It should be noted, however, that from the researcher's perspective there were no issues observed in practice or reported by the DNs at interview that caused concern.

Ethical issues and limitations of observation as a method have been discussed in Section 7.2.1 and it is important to acknowledge that the interpretation of the researcher is subjective. The inherent difficulties in exploring the knowledge based in the practice of experienced nurses have been alluded to throughout this study. However, it is felt that through the description of the research processes and the efforts taken to enhance the trustworthiness of this study, attempts have been made to support the researcher's interpretation of the findings (Chapter 3).

7.2.7. Issues of rigour and trustworthiness

In Chapter 3 Section 3.15, the criteria for judging the trustworthiness of the study were identified and explored. It was acknowledged that establishing the relevance of the study findings to those concerned was an important part in ensuring the rigour of the research process. This is particularly important in ethnographic research where the presentation of quotes from data is selective and assumptions may be drawn from 'illuminating

singularities' (Dey 1993 Pg. 222) which portray a particularly vivid picture of the phenomena under study. Looking for corroborating evidence is proposed as one way in which the errors associated with neglecting data can be avoided (Dey 1993).

In this study, examples were assessed for their relevance by checking across the whole data set and assumptions and hunches were discarded if the analysis process could not confirm them. The process of looking for contrasting cases and reflecting upon how the issues emerging related to the whole data set was important, a process facilitated by sharing several data sets with the three supervisors. Many of the examples cited in Chapters 4, 5 & 6 are lengthy and allow the reader to judge the interpretation presented by the researcher. As a final measure to ensure that rigour was enhanced, the study participants and the nurse manager, who supported the study, were given a paper providing an overview of the findings. This paper included details of the five themes presented in Chapter 4, a description of the five stages of assessment distilled from the study data (Chapter 4), and the six dimensions from the typology of district nursing knowledge (Chapter 5).

The participants were invited to attend a meeting in order to discuss the study findings. Inevitably, in a study which involved participation over a three-year period, a number of participants could not be contacted or could not be involved further for a range of reasons including, retirement, pregnancy and changes in employment. Seven of the participants were still working in the same post and three were able to provide feedback.

The discussion lasted around one hour and was recorded. The DNs were asked to comment on the materials presented in relation to the following:

- Does the account presented 'make sense' – does it resonate with your perceptions of what you do?
- Are there any surprises?
- Are there any areas that you would have expected to be identified that are not?

The participants were extremely supportive in their comments and the overall feelings were that the findings painted a clear, true and accurate picture of their work. The DNs stated they had not read anything that had described their work in the way the findings were presented and that the interpretation untangled the complex job they undertook. One DN stated:

“I feel that your research will be incredibly useful to the profession, particularly DN students and other professions in explaining the complex and multi-faceted job that we do”.

The other DNs also agreed that the findings would be useful in explaining to colleagues what they were trying to do and why. The DNs agreed that there were no great surprises but that the account represented what they did and formalised their work.

Another interesting point made was that the DNs themselves did not acknowledge how complex what they actually did was. The DNs agreed that the interpersonal skills elements identified by the study were important and appropriate. They also felt that they had learned to assess through ‘doing’ rather than theoretically.

The DNs did not identify any areas of assessment as missing or irrelevant. One DN stated “I didn’t realise there was as much going on”.

An interesting comment was made in relation to the Model of District Nurse Assessment (Figure 2) which the researcher discussed with the DNs at the meeting:

“I think the model’s very good in the fact that you’ve not given anything a weight of importance over anything else...because it all impinges on you in different ways at different times...”.

It was agreed that the findings could be used with students although the DNs identified that pre-registration students tended to focus on the physical tasks. The findings of the study may therefore be more relevant to DN students and experienced DNs.

One DN noted that she and her colleagues had set up a Clinical Reference Group whose task was to review the first assessment visit. The group asked the researcher if they could use the findings in their discussions.

It is acknowledged that this discussion in relation to the relevance of the study findings is derived from only 3 DNs. However, each had shared and discussed the findings with colleagues who had also commented on their relevance. Hammersley (1998) stated that an important feature of assessing the value of findings of ethnographic research is the participants’ assessments of the value of the findings for their practice. The DNs confirmed

the findings and their relevance and it is felt that this enhances the overall trustworthiness of the interpretation.

7.3. Review of the theoretical underpinnings of the study

It is important to review the theoretical underpinnings of this study within the context of the debate existing in relation to how central the use of theory should be in inductive, qualitative research. Theories can provide a set of explanatory concepts, which offer different ways to view the world (Silverman 1993) or the phenomena under study (Chinn and Kramer 1999). Theories can be used at different levels and for a range of purposes. The challenge for the researcher carrying out an inductive study is to strike a balance and use extant theory in a manner appropriate to the phenomena under study.

Sandelowski (1993) proposed that in qualitative research, theory could be used centrally or peripherally. Theory can be used centrally and the starting point for some ethnographic studies may be a defined theory from which a set of hypotheses can be derived. However, normally, ethnographic research aims to produce descriptions and explanations of phenomena or develop theories rather than test existing hypotheses (Silverman 1993; Hammersley and Atkinson 1995; Hammersley 1998).

Ethnographic studies, therefore, use theory normally in a more peripheral manner. Such peripheral use of extant theory is crucial to ethnographic research and reflects:

“...the extent to which the particular subject-matter of the ethnography is located in wider conceptual frameworks” (Hammersley & Atkinson 1995 Pg.257).

Sandelowski provided a useful description of the peripheral use of theory that was relevant to this study. She described the notion of ‘brush stroking’ theory to enhance the interpretation (Sandelowski 1993). Throughout this study, existing theory was used in different ways to help the researcher enhance and refine the emerging themes and patterns. For example, the theoretical frameworks which exist in the nursing knowledge and decision-making literature were used during data analysis.

In relation to nursing knowledge, the use of existing theoretical frameworks such as that of Carper (1978) proved fruitless as the data from the study did not ‘fit’ with the fairly rigid

and context-free parameters outlined in this framework. This resulted in a different approach to the data analysis where the intent was to explore the emerging concepts in relation to their context in order to retain a sense of the 'whole'. In contrast, the conceptual framework by Carroll and Johnson (1990) provided a useful theoretical framework from which to explore the breadth of the decision-making process in district nursing assessment. Use of this conceptual framework, arguably, enhanced the interpretation of the decision-making process contained within Chapter 6. Throughout the study, literature was consulted in a number of areas including the role of family carers, family nursing and communication.

The theoretical underpinnings of this study have sought to balance the inductive nature of the study with the reflexive use of existing theory in order to enhance and illuminate the findings for district nursing practice.

It was stated in Chapter 1, that the opportunity to develop theory was the starting point for this research and that this possibility influenced the choice of research approach. The outcome of a qualitative study may be a 'locally grounded theory' which may be identified as a 'pattern model'. This model seeks to explain and demonstrate the connections between the phenomena under study and illuminate the relationship of these phenomena to the whole picture revealed by the research (Lincoln and Guba 1984 Pg. 49). The model of District Nurse Assessment (Figure 2) and the Typology of Knowledge for District Nursing Practice (Chapter 5) have been developed in order to illuminate the process of district nurse assessment. Further testing and refinement are crucial in order to enhance understanding of district nurse assessment practice.

7.4. Recommendations

To offer prescriptive recommendations based on the findings of this study would not be appropriate given the inductive nature of the study and its small sample. The key issues identified by this study have implications for future research, and for the practice and educational contexts of district nursing.

Research

The first recommendation is derived from the complex and ongoing nature of assessment in DN practice revealed by the study. Further research to explore the assessment process over a longer period of time would help to capture the ongoing nature of assessment in DN practice and to test/refine the model of DN assessment and typology of knowledge presented in the study. As the model and typology were developed from data relating to the first visit, it is not clear if and how they may relate to ongoing assessment. A future study, carried out on a longitudinal basis and focussing on patients' requiring care for non-curative illness, is crucial to allow the model and typology to be tested and refined.

If knowledge is predominantly experientially derived as suggested by the findings of this study, then it may prove useful to involve both experienced and less experienced nurses (perhaps students) in further study to capture and explore how DNs learn about the assessment process.

The significant number of cues utilised by the DNs in this study were noteworthy and crucial to the assessment process. It therefore seems important that future research should focus on the nature of the cues identified and used by DNs and, in particular explore, why DNs hone in on some cues rather than others.

Professional and policy context

The findings from the study have implications for the professional context of district nursing. The skill mix of the district nursing team is changing. Fewer nurses are able to undertake education courses leading to qualification as a DN. Additionally, fewer qualified DNs are being employed in practice whilst the numbers of registered and unqualified staff working in the community have increased (Information and Statistics Division The National Health Service in Scotland 1996). The DN is also assuming more of a team leader role from which she delegates the care of patients to other grades of staff following the first visit.

The findings of this study suggest that the changes in professional context outlined above need to be carefully monitored and evaluated. This study has demonstrated that DN assessment is highly skilled work based on a complex and integrated knowledge base. An extensive range of skills is evident, including those related to cognition, direct care-giving,

communication, interpersonal relationships and team-working. The complex and continual nature of assessment and the relationship to the knowledge and experience of the DN revealed by this study, suggest that to restrict the contribution of the qualified DN to the first assessment visit is likely to impact on patient care. The issues identified by the DN as being salient stemmed from her knowledge and experience. If DN practice is regarded as a developing process, where 'getting to know the patient' is crucial, it seems essential to extend the skilled assessment contribution of the DN beyond that of the initial visit. The findings of this study challenge policy recommendations which seek to reduce the number of qualified DNs (National Health Service Management Executive 1992) and counter claims that DN assessment is unfocussed and generally of poor quality (Audit Commission 1999). Further research investment in explicating skilled practice and decision-making and in uncovering its knowledge base is important to inform policy decisions and to guide education.

Additionally, the study has revealed the importance of the role and contribution of the family to the care of the patient and the complex family dynamics within which the DN has to work. There was limited evidence that the DNs in this study captured within their documentation the nature of the intervention required with family members. In order to capture and secure a platform for the exploration of this important aspect of DN work, it seems crucial that DNs acknowledge and formally record this part of their work.

Educational Context

It is suggested that the findings of this study have implications for the manner in which DN students are taught about assessment practice. The findings suggest that such learning has a significant experiential component, with the context in which the interaction takes place determining much of the process.

The use of an abstract, theoretical assessment framework does not seem to suit the reflexive assessment process in district nursing practice. Work-based learning and/or problem-based learning appear to offer opportunities for teaching/developing this area of practice.

Whilst learning from experience in the workplace has been integral to community nurse education programmes in the form of taught and supervised practice, there is increasing

recognition that community nurses need to be self directing in their learning and able to reflect critically on their practice (Walker et al. 1998). Work-based learning is characterised by the responsibility of the student to plan, implement and evaluate learning in practice in conjunction with academic and professional support. The study by Walker et al (1998) which evaluated work-based learning in relation to qualified community health practitioners undertaking a post registration degree programme, acknowledged the potential of such an approach to advancing professional practice. Given the context driven nature of district nurse assessment, it seems necessary for DN students to be given the opportunity and skills necessary to explore, evaluate and develop their assessment practice within a supportive learning environment.

Personal reflection

At the outset, I wanted the findings, whatever they were, to inform every day district nursing practice. My experience as a DN has been central to the approaches adopted throughout the study. Knowing many of the DNs prior to their involvement in the study was beneficial and I think enhanced the ways in which they described their practice. The DNs were relaxed and willing to talk about practice, seemingly reassured that I was not there to evaluate their practice. In the final stages of the study my thoughts have turned towards working out how every day practice might benefit through sharing the rich insights provided by the study participants.

Finding appropriate ways to help students, who are experienced nurses, understand and develop their knowledge and skills in decision-making, is challenging. As a teacher, there are a number of ways in which I will use the findings. The model of DN assessment has provided information about the process of assessment which will help students to understand the reflexive nature of the assessment process. The typology, which identifies 6 ways of knowing, can offer some useful principles, lacking in current literature, for DN assessment practice. There exists potential to develop a learning package to combine the theoretical models with the practice examples.

I have already used data extracts such as that provided by DN 3 when she described ‘making the visit work’ (Chapter 6) at sessions exploring communication. The students enjoyed the use of real life examples and were able to analyse these in relation to their own practice and communication theories.

Undertaking this study has been illuminating for my own practice as a teacher. Throughout, I have been able to draw on learning from this study to inform my own teaching about research methods and nursing knowledge and decision making. I have become increasingly aware of the need to challenge existing theoretical models and assumptions contained within current literature and propose that some of the findings from this study can contribute to the debate as to how experienced nurses use knowledge in practice.

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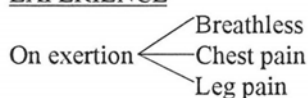
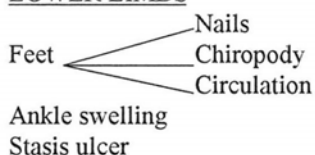
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Appendix 1

Prompt List for Health Assessment of the Elderly

MOBILITYEXPERIENCELOWER LIMBSSKIN

Itch

Pressure areas

VISION

Reading

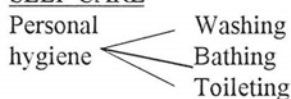
Glasses

HEARING

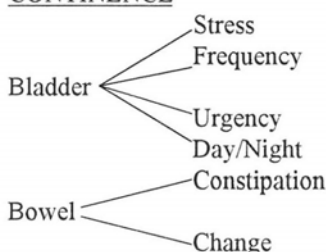
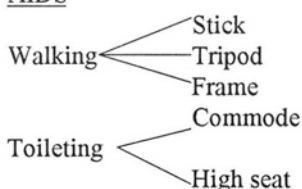
Doorbell

Normal conversation

Aid

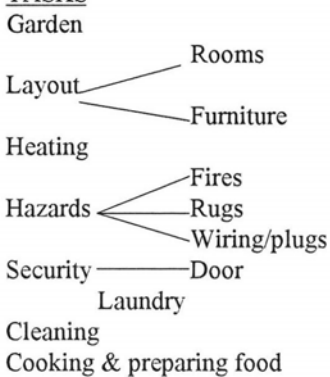
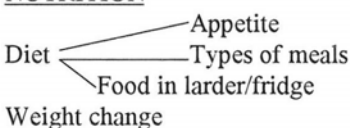
SELF CARE

Dressing

CONTINENCEAIDS

Bathroom

Kitchen

HOUSE & HOUSEHOLD TASKSNUTRITION

State of teeth/dentures

FINANCE

Benefits and pensions

LEISURE & INTERESTS

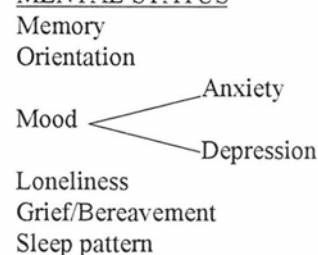
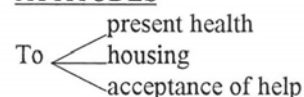
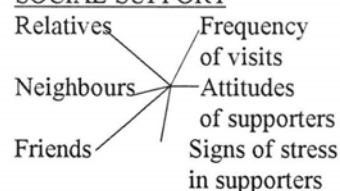
TV/Radio

Reading

Pets

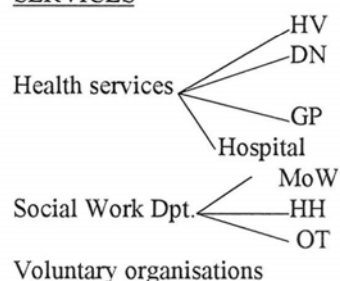
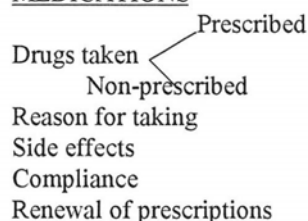
Outings

Smoking and alcohol

MENTAL STATUSATTITUDESSOCIAL SUPPORTCOMMUNICATION

Help in emergency

Telephone

SERVICESMEDICATIONSMEDICAL HISTORY

Appendix 2

District Nurses Biographical/Professional Data

Name.....

Age Group 21 - 29
 30 - 39
 40 - 49
 50 - 59
 60 and over

Work Base.....

Grade.....

When completed DN course.....

Name of Award.....

Where completed DN course.....

Other professional qualifications (with year).....

.....

Current DN post.....

Previous DN Posts.....

.....

Details of educational activities undertaken since completion of DN Course

.....

.....

.....

Details of educational courses which are currently being undertaken

.....

.....

Appendix 3

Letter of approval from Research Ethics Committee

Dear Ms Kennedy,

Request for Ethical Approval - 1702/97/2/4: The Nature and Use of Knowledge by District Nurses in Decision-Making Relating to First Assessment Visits

Thank you for submitting the amendments or additional information requested by the Sub-Committee for the above protocol. The Chairman of the General Practice/Public Health Medicine Research Ethics Sub-Committee has now agreed to grant ethical approval. This approval encompasses all aspects of the application including the Patient/Subject Information Sheet and other accompanying documentation.

Under the terms of the Scottish Office Home and Health Department Guidelines on Local Research Ethics Committees this decision has been notified to the NHS body under the auspices of which the research is intended to take place. It is that NHS body which has the responsibility of deciding whether or not the research should go ahead taking account of the advice of the Research Ethics Sub-Committee.

A condition of this approval is that you are required to notify the Sub-Committee, in advance, of any significant proposed deviation from the original protocol. Reports to the Sub-Committee are also required once the research is underway if there are any unusual or unexpected results which raise questions about the safety of the research.

In addition, researchers are required to report on success, or difficulties, in recruiting subjects in order to provide useful feedback on perceptions of the project among patients and volunteers.

Please quote the above reference on all correspondence

DEACONESS HOUSE

148 PLEASANCE EDINBURGH EH8 9RS

TELEPHONE: 0131 536 9000 DIRECT DIAL: 0131 536 9050

FACSIMILE: 0131 536 9346

The General Practice/Public Health Medicine Research Ethics Sub-Committee is fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) Guidelines for the Conduct of Trials Involving the Participation of Human Subjects as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of the European Union on 17 January 1997. The following documents were included on the computer disk containing the guidelines and application form and are available on request:

- Membership List
- Standing Orders
- Statement of Compliance

Yours sincerely,



Linda Semple

Secretary

General Practice/Public Health Medicine
Research Ethics Committee

Appendix 4

Interview Schedule for District Nurses - Interview 1

Part A (Setting up/introductions)

Initial introductions and acknowledgement of agreement to participate

Re-emphasise the purpose of the interview

Re-emphasise confidentiality and freedom to withdraw

Seek permission to record interview and set up recording equipment

Thank you for agreeing to be interviewed this afternoon. Please remember that you are free to stop this interview at any time if you feel unhappy. So that I can listen carefully to what you are saying I would like to record our conversation. Is that OK?

Part B

(Background information)

Can you remind me where you completed your DN course?

Can you tell me briefly about the posts you have held since you finished the DN course?

(perceptions of first visits)

As you know, I am interested in what is going on when you visit a patient for the first time. Could you tell me what you think are the important things that happen at a first visit?

(focus on actual visit)

When we visited (name of patient) today could you tell me what were the things that were going through your mind?

Was there anything you said or heard which particularly sticks in your mind?

At the visit you told the patient that....or/andwould happen. Why did you make these decisions?

Were there any questions that you did not ask or pursue at this visit?

There are perhaps different options as to what you could have done for this patient - why did you follow that particular route?

What do you think influences the decisions you make? (decision to act and/or observe)

Other nurses say that sometimes they are in a situation where they cannot do what they want to do - does this ever affect you?

Have you ever entered a house and felt completely at a loss as to what to say or do?

To what extent was this interview typical of what you would normally do in a first assessment visit?

Are you satisfied with what you did and did you achieve what you wanted?

Is it the same as you thought you should do?

Are there any particular issues, which you will pursue at the next visit?

If I were a student what would you want me to have got out of that visit?

Part C - (conclusions and thanks)

Is there anything at all you would like to add in relation to any of the points raised?

Is there anything you would like to say about the way this interview has gone?

Thank you very much for your co-operation, I would like to assure you that confidentiality will be fully respected.

Appendix 5

Interview schedule for district nurses – Interview 2

The aim of this interview is to explore further the issues raised from the Phase 1 data. In particular, to explore the concept of relationship in relation to first visits, to uncover how the DNs have learned about first assessment visits from previous experience and to explore further the areas of knowing identified in the typology.

Question 1

Do you consider that first assessment visits are different to other visits that you carry out in your role as DN?

Question 2

If so, in what way do you think first assessment visits are different?

Question 3

Obviously the reason for referral is all you have to go on prior to the visit. Do you think that the given reason for referral influences your assessment at the first visit?

Question 4

If so, in what way?

Question 5

Often the reason for referral is task based, i.e. needs bathing, rather than patient based, how do you feel about this?

Question 6 (*given to DNs in advance of interview to allow them to think about their response)

Think back to a recent first visit, can you recall the referral information you were given and can you recall the decisions you made. Having completed the visit what were the key factors that influenced your decisions?

Question 7 (*given to DNs in advance of interview to allow them to think about their response)

Reflecting on previous actions is currently viewed as an important way of nurses learning through their own practice. Could you recall a significant incident that has resulted in learning in relation to first assessment visits?

Question 8

In the first interviews you and your colleagues talked a lot about the importance of establishing a relationship with the patient and family. What kind of relationship are you trying to establish at the first visit?

Question 9

At the first interview you and your colleagues highlighted the importance of the family. Does the presence or not of another family member influence the decisions you might make at the first visit? If so, in what way?

Question 10

Apart from completing a necessary task at the first visit, if you were only to achieve one other thing the first time you meet a patient and/or family, what would it be?

Question 11

What makes a first visit a good visit as opposed to a bad one?

Question 12

Getting to know the patients in their own home seems to be important to DNs. What sort of things do you need to know to achieve this?

Question 13

Getting to know carers or family members seems to be important to DNs. What sorts of things do you need to know to achieve this?

Question 14

At the first interview some DNs identified that in certain situations they liked to keep contact with some patients 'just in case' they had future care needs. Could you comment on this as part of the DN role?

Question 15

As the DN role develops there is an increasing expectation that DNs will expand their knowledge base. Are there any areas that you think you need to or would like to develop in order to allow you to meet the needs of patients and families more effectively.

Question 16

How could those educational needs be met?

Question 17

Please make any other comments in relation to the work of district nurses in relation to first assessment visits.

Appendix 6

District Nurse Consent Form

- I agree to take part in this study
- I have had verbal and written information from Catriona and understand this is a PhD study on first visits in district nursing
- I understand that Catriona will respect my decisions regarding the suitability of the patient for the study

Signature of District Nurse

Name of District Nurse

Signature of Researcher

Two copies to be made:

Top copy to be retained by researcher

Second copy to be retained by district nurse

Researcher

Mrs Catriona Kennedy
Lecturer
Marie Curie Centre, Fairmile
Frogston Road West
Fairmilehead
Tel 0131 445 2141

Supervisor

Ms Phyllis Runciman
Senior Lecturer
Department of Health & Nursing
Queen Margaret College
Edinburgh EH 12 8 TS
Tel 0131 317 3563

Appendix 7

Patient Consent Form

- I agree to take part in this study.
- I have had this study explained to me and have received written information from Mrs Kennedy about it. I understand this is a PhD study on first visits in district nursing. I have had an opportunity to ask questions about taking part in the study.
- I understand my General Practitioner will be informed.
- I understand that, even although Mrs Kennedy has visited me, I am under no obligation to allow the visit to form part of the study.
- If I ask Mrs Kennedy not to use information it won't affect my care from the DN.
- I understand that I cannot expect to benefit directly from the study, as a patient.

Signature of Patient/Carer*

Name of Patient/Carer*

Signature of Researcher

Date -----

*Delete as appropriate

Three copies to be made:

Top copy to be retained by researcher

Second copy to be retained by patient/carer

Third copy to be sent to patient's General Practitioner to be filed in medical notes

Researcher

Mrs Catriona Kennedy
Lecturer
Marie Curie Centre, Fairmile
Frogston Road West
Fairmilehead
Tel 0131 445 2141

Supervisor

Ms Phyllis Runciman
Senior Lecturer
Department of Health & Nursing
Queen Margaret College
Edinburgh EH 12 8 TS
Tel 0131 317 3563

Appendix 8

Information sheet - District Nurse

Dear

Following our telephone conversation I would like to thank you for your willingness to take part in my research study that will explore first assessment visits in district nursing.

I am trying to find out the nature of district nursing expertise in relation to first assessment visits. It is anticipated this research will give important insights to what happens at first assessment visits and inform course planning for future district nursing courses.

In order to learn more about this I would like to accompany you on a visit to a new patient. Following the visit I would like to talk to you about the visit. If it is OK with you, I would like to tape record the conversation so that I do not have to write everything down. Please say if you object to this. The time required for the interview will be around an hour.

You may stop the interview at any time and can be assured that the information given will be confidential and no names will be used in any written material. The data will be destroyed one year after completion of the research. I will be pleased to provide you with a summary of the findings when the research is complete.

As notice of new patients may be short I will keep in touch with you and I would be obliged if you could give me a ring when you know of any new visits which need to be done and a date and time has been set aside.

If you require further information please do not hesitate to contact me on 0131 445 2141.

I look forward to meeting with you.

Yours sincerely

Catriona Kennedy
Research Student/Lecturer

Appendix 9

Information sheet - Patient

Dear

Thank you for allowing me to be with your district nurse when she called today. I asked you if I could be with the district nurse because I am doing a research study about first visits.

Visiting patients in their own homes is a very important part of the district nurse's role. I am trying to find out what happens when the district nurse visits you for the first time and the skills she uses.

In order to learn more about this, I am accompanying some district nurses on their visits. You may have noticed that I was taking notes while the nurse was talking to you. This was simply to remind myself what was happening at the visit. I can assure you that any information given will be confidential. No names will be mentioned in my study.

It is important for you to understand that you are under no obligation to take part in this study. If you decide not to take part you are assured that future care from the district nurses will not be affected in any way.

Thank you very much for your help. I hope the study will give us important information about the work of district nurses.

If you or any of your relatives have any further questions please feel free to contact me on 0131 445 2141.

Yours sincerely

Catriona Kennedy (Mrs)
Research Student/Lecturer

Appendix 10**Information sheet - General Practitioners**

Dear Doctor

I am writing to confirm to you that I recently accompanied a District Nurse on a visit to your patient.

I am currently carrying out a research study, which is exploring first assessment visits in district nursing. It is anticipated this research will give important insights to what happens at first assessment visits and inform course planning for future district nurse students.

Verbal and written consent has been given by the patient and assurance given that no names will be used in any reports in published materials associated with the research. The Lothian Research Ethics Committee has approved the study.

I will be pleased to provide you with a summary of the findings when the research is complete.

If you require further information please do not hesitate to contact me on 0131 445 7794.

Yours sincerely

Catriona Kennedy
Research Student/Senior Lecturer

Appendix 11

Example of field notes - District Nurse 4

Non-participant observation

Visit took place on 26.8.97 and field notes written 26.8.97

Demographic details

Experienced DN who is the caseload holder. Works with two other G grade caseload holders and a relief G grade DN. There is also a B grade bathing auxiliary. Has worked in this area for 15 years and completed DN course at Castle Terrace in 1971.

Referrals

The DN has three new referrals for this afternoon. Two patients referred by local hospital and third referred by member of the community. Referral one was to check the blood pressure of a lady who was being treated for hypertension and had started new medication. The second referral was to a lady who had undergone day surgery for surgical repair of a hernia. The last referral from a member of the public was to a lady who the DN knew of but had not visited. She was a known alcoholic and had been seen in the town in a very unkempt state.

DN comments prior to entering house - Visit one

DN said she had been asked to check the blood pressure of this lady who was taking new medication for her hypertension. She had no more information at this stage but anticipated that she would require visiting on two occasions only "unless something unexpected turned up".

The visit

The patient herself answered the door and seemed a little anxious when she saw us there. Comfortable home and the patient invited us into her sitting room and to sit down. Patient (77 years old) sat in what looked like her usual chair and the DN sat on the settee initially.

Information seeking

DN said to patient that she believed she had started on new medication - yes. DN asked who had prescribed these - patient answered the GP. DN asked how long she had been taking them and did she understand what they were for - patient knew they were for her BP and she was due to return to the hospital next week for monitoring.

At this point the DN was using the carded and was writing demographic information about the patient. DN at this point moved closer to patient when she was asking about medication as there were some boxes lying on the coffee table - discovered some of these were previous tablets and the DN advised the patient to throw these out.

DN asked about help in the home - patient has home help twice weekly. Her daughters who both live in England had been visiting recently. The DN asked about what the home help did and was it enough? The patient said it was fine. DN continued to take details of next of kin.

Patient goes back to local hospital on Monday and the DN asked the patient if the GP or the hospital wanted the result - patient not sure so DN said she would notify both. DN said she would return on Friday and do the BP again.

DN at this point took the patients BP and said it was "not bad" although she was not sure what it was before. Patient did not ask what the reading was and the DN did not tell her.

DN then asked patient about how she managed to bath - patient said OK although she was waiting for new aids. DN asked if the occupational therapist had been - not yet. Said she would follow that up. DN asked patient if she got out - yes - but needs a taxi.

DN asked if there was anything else she could help patient with - no. Said she would be back on Friday and we left.

Cue following

DN followed some visible cues - for example the medication on the table. The patient walked with stick and she asked her how she managed to get out and about. The home was comfortable and well maintained and the DN asked about help. The patient actually looked very well and the DN asked about her appetite. The patient did not volunteer a great deal of information over and above that asked for by the DN. However, after her initial anxiety (our perceptions) she relaxed quickly and there was laughter and discussion throughout the visit. She showed no inclination to know her BP reading and appeared content with the DN's comments that "it was not too bad".

DN perceptions post visit

Pleasant lady who initially appeared anxious but quickly relaxed. Looked well and very contented with life in general. DN thought that in the future she could need some further help but everything was OK just now. Return visit on Friday to monitor blood pressure. Useful that the patient now had met her if she needed help in the future. DN thought it had been a good visit.

Researchers observations

Visit was structured in parts - where DN used kardex to record factual information - but responsive to the patient generally. I was surprised that the DN did not tell the patient the BP reading but on reflection I think she was right - the patient seemed perfectly content and showed no inclination to know.

Notes

When I further explained after the DN was finished why I was there to patient she did not really appear to be concerned in any way. Gladly signed form - it is difficult to explain in

any detail when patients are so agreeable - I wonder about having to get them to sign at this stage (second visit this week).

Referral - Visit two

This referral came from the day surgery unit at the local hospital. Patient was 67 year old lady who had repair of hernia yesterday (Monday) and DN was asked to check wound.

DN comments prior to entering house

Anticipated that only one or maybe two visits would be required. Thought she might know this lady. DN thought day surgery was "great" and thought there was a steady increase in the numbers of cases being referred to the DN service.

The visit

Patient's husband answered the door and invited us in to the living room where patient was lying in bed in front of the T.V. Cluttered but comfortable home and the patient greeted us warmly. DN recognised patient who had worked in a local shop for a number of years.

Information seeking

DN confirmed that patient had had her operation yesterday - yes, patient went into hospital at 9am and got home around 6pm last night. DN was standing beside patient at this point. DN asked how the hernia had developed. Patient said it occurred after a gall bladder operation. DN asked if she had problems eating - no - main problem was pain when it was touched or bumped and she worried about her boisterous grandson running into her. This led the DN to ask a series of questions about her family. As DN was doing so she filled out Kardex, checking details of name, address, date of birth, GP.

The DN then advised the patient about lifting and hovering and the need to avoid this for some time. She also advised the patient to support her wound when coughing, laughing and sneezing.

DN then checked the wound and at this point advised the patient to take a daily bath or shower. Told patient she had dissolving sutures in so they would not need to be removed. Told patient the wound "looked lovely" and was clean and dry.

The DN told the patient to get up tomorrow and have a bath or shower and then apply a Mepore dressing - DN showed patient how to use these and the patient seemed very happy about this. DN left some dressings for patient.

DN asked the patient if she was worried about anything - no - DN left contact name and number. Told patient to contact her if worried at all - said that very occasionally wounds became infected and described to her how this might present if in fact this did happen.

DN told patient to take it easy and gradually do more - again re-emphasised the need to be careful about lifting and also talked about shopping - patient said husband dealt with all

those things. DN said it was important for her to get up and move about but not to lift for at least one month.

DN asked patient if she had anything to ask - no - patient said she was eating well and she was glad she had had her operation. Husband came back into the room at this stage and chatted generally about his role in relation to shopping, cooking etc. Some general chat about where she used to work and how she recognised the DN. We then left and husband showed us out. DN told him on the doorstep to get in touch if he was worried.

Cue following

DN focused part of the visit on the actual wound but was chatting about a number of different things at the same time. She gave advice on caring for the wound and protecting the patient (in relation to lifting etc) after the operation. The patient was lying in bed in the living room and the DN told her it was important to get up and move around but without doing too much.

DN perceptions post visit

Pleasant lady who seemed very well and certainly the wound looked fine. Looked very happy and contented lying in her bed in the living room - DN joked maybe too happy. No need to go back - they know where to contact her.

Researcher's observations

Fairly short visit. Patient completely at ease with us visiting, lots of chat and laughter. Patient appeared satisfied with the visit - appeared not to have any significant worries. Seemed happy to follow advice of DN and knew she could contact her if necessary.

Notes

Again this patient readily agreed to the study - did not seem to want lots of information - giving very "potted" information but consent form and information letter left with contact number.

Referral - Visit 3

This referral came to the DN from a member of the public. Patient is a local lady who is an alcoholic and known to the Health Centre Staff. Patient had been seen in the town, unkempt and covered in faeces. DN seemed anxious about this visit. When we drew up in front of the address the DN said the house was very neat and tidy and the DN said I don't think this is right. She spotted a house across the road which looked run down and said that looks more like what I am looking for (both houses had same numbers but different street names although they were opposite). She was correct - other house was patient's home. We knocked on the door - no response. Went round the house - some curtains drawn, DN looked through letterbox and was overwhelmed with the smell. Did not want to go away without tracing patient so knocked on neighbour's door (she knew her) to ask if she knew anything about the patient. Neighbour invited us in and tried to telephone

patient - no response, she then telephoned another neighbour who said the patient had gone to the church, to see Father Barry. In the end the DN seemed relieved to have traced the patient and said she would have returned tonight if she had not found out where she was.

Researcher's notes

Although we did not see the patient this highlights a very clear example of cue following in relation to the house and powerfully illustrates the way DNs observe and make judgements based on environmental factors. DN was not going to leave this area until she had exhausted the possibilities about finding out about the patient - said she would not like to think the patient was lying ill or dead in the house. DN said she would have visited in the evening (her own time) if necessary. Also illustrates how DNs use their contacts in the community - neighbour was known to DN who had nursed her husband and part of the time in the house focused around the DN and neighbour catching up.

Appendix 12

Example of code notes and story line for DN 1 - 12 February '98

Code note: Broader outlook

(DN1 words – broader outlook, thinking broadly, looking further, thinking laterally, looking beyond)

*Broader than what and in relation to what?

DN1 raised these concepts on a number of occasions throughout the interview–

(Pg. 2 para2) – when asked about which aspects of DN course prepared for her for role:

“I think they gave you a broader outlook” and goes on to say “rather than thinking about just the patient, all the other things that affect a patient and their family”

Identifies subjects – sociology, psychology, benefits, CC Act. Thought that supervised practice was useful in helping you to ‘think more broadly’

*What did she think this broader outlook is and why is it necessary?

(*What does ‘family’ mean to DNs? – not directly related to this code but useful to keep in mind)

She goes on to compare the context of care in the community to hospital:

“In hospital you tend to think every thing is there for you all the time and that’s it”

* ‘That’s it’ – does this mean that she thinks the context – community relates to this need for a broader outlook?

When asked about gaining confidence in doing first visits (something she identified she did not have when she finished the course – had the knowledge but not the confidence) again she talks about going in, seeing people, *thinking broadly*, bringing in the knowledge (Pg. 2).

When asked if she used a framework for assessment (Pg. 4) she now uses the words ‘thinking beyond’ what the one word means and gives the example of mobility and again highlights the differences between hospital and community and the tendency to think more broadly.

When talking about getting the information to base decisions on she talks about “looking further than what they say” “It’s about looking further and stopping and thinking about can they really manage?” (Pg. 8) – *so how does this relate to broader outlook and thinking broadly?

When talking about skill mix she talks about the differences between the G grade and the E Grade – “...but they don’t seem to think laterally at all, they seem very much looking at the task of what we are going in to do and can’t almost cope with anything else that is going on around”.

*If this is so, what makes the G grade *think* (and therefore act) in a different way (this of course cannot be applied across the board to all G grades surely?). Is it the knowledge – from the course, from experience of assessing patients, from life, own personal beliefs and values, all of these?

DN talks about using the knowledge and bringing it all together when asked what she thought the difference between the G and E grade was all about (Pg. 13 para1). She then later gives an example (Pg. 13 para5) of a patient with oedematous legs who won't keep them up and "it's about looking beyond and saying well why doesn't she?"

Thoughts

It would seem from this first interview that there could be a category developed around these concepts. This category has different dimensions

- Having a broader outlook and the influence of the DN course and practice in bringing that about – relationship to knowledge?
- Needing a broader outlook because of the context of care – hospital – community
- The need to think broadly in relation to doing first assessment visits – using frameworks in a broad way
- The need to look further when working with patients and families – this is almost about not believing (in the best possible way) or not taking at face value what the patients and families are saying
- When talking about the abilities of staff relating the grade and experience of the nurse to the ability to have this broad outlook

Help! How do you untangle this lot?

I think broader outlook could be important in relation to the exploration of knowledge and maybe I need to frame a question around broader outlook and knowledge to see what they come up with.

Possible question for second interviews:

DNs have been telling me that you need a broader outlook and knowledge base to do first assessment visits in the community. Can you tell me what you think that is about?

Interview 1

Code note: The main thing

This is an interesting concept, which on my first thoughts seems to be almost a contradiction to the above concept of "broader outlook"

Whilst the above notes highlight the emphasis this DN puts on taking a broader outlook she raises the issue of thinking about *the main thing*.

When asked what sorts of things were going through her mind when assessing the patient she says:

“Em I think the main thing was that the em woman’s husband was very, you know, appeared as though he was coping but in fact I would say he could probably do with a bit of help” (Pg. 5 para5). She seems to be saying at this point that the main issue or problem in the house is in fact the carer.

She then goes on to say: “Well I think, it appears that the main problem for them is bathing although I would have to query that in that he said “oh no it’s not a problem”. (Pg. 6 para4). The DN seems to go back to the original reason for the referral – bathing – although she does indicate that this might not be so.

*Why does she use the main thing/problem – is it to justify the decision to involve or not the DN service? Is it the search for something that DNs can readily identify with and give them a reason for being there? A bath is a task.

She then goes on to describe another ‘tactic’ to sort this out – “what did she (the patient) think was the main problem” (Pg. 6 para. 6). It is interesting to note from the field notes that at one point the DN asked the patient “what is your biggest worry?” so she did try to ‘sort’ this at the visit.

She goes on “Em obviously I get the picture that he’s a bit stressed, be that physical or mental, I’m not completely sure, em, obviously physically because he’s got a sore back, he’s doing things he doesn’t need to do so I need to really go back and try to sort out what is the main thing in there” (Pg. 6 para6).

At this stage the DN was not going to make the decision to offer the service on a long term basis – she wanted to go back to get more information on which to base her decision. Although she identified above that bathing might not be the “main thing” her next visit was going to revolve around the DN and patient going through the process of bathing together. So despite her reservations about the *main thing* and what it was she was focussing on bathing for her return visit.

Bathing was the reason for referral and at this point I am wondering how this relates to decision making literature which suggests that doctors and nurses employ the hypothetical-deductive approach where they set out to confirm or refute the original diagnosis (Doctors) nursing issue, or in this case the reason for referral.

My hunch is at this stage that this DN was in fact looking for evidence to confirm the need for bathing. She does talk about having the referral in her mind (Pg. 3 para. 2)

“Well the, obviously the referral from where ever it is will tell you a little bit about what you are going in to or what you think you are going into, so obviously that’s something that’s in my mind before I go in, em and it’s something that I will look for quite quickly you know try and get round to that quite quickly...” (Pg3 para. 2)

Thoughts

This is quite complex and needs exploration at the next round of interviews – but again – how do I do this? I know from the other 10 interview that in various ways the DNs talk

about broader outlooks and holistic care but all the visits and the actions of the DNs seem to have focussed on the reason for referral, which has been the main task. Until I explore further I am not sure if any of the others use this term the main thing – I don't think so but I am sure there will be lots more which relates to this.

At this stage I think I will use "The main thing" as the category as the literature talks about using 'spontaneous participants terms'.

Possible question for second interviews:

Do you think that there is often one main thing from what you have seen or heard that influences you when you visit for the first time?

Interview 1

Code note: Interpreting information and correct information

The whole issue of information is fundamental to the assessment process and DN1 talks about getting correct information and linking this to the interpretation that the patient, family and DN may put on it. She talks about 'investigating' what's going on at one point in relation to the difference between the G and E grade nurse (Pg.12 para 6). I have decided to deal with the issues relating to information together as getting appropriate correct information and interpreting it accurately I assume is where all the DNs will want to get to at the end of the first visit. (Information seeking is one of the headings for the field notes from observation visits).

Getting information –

Written information when asked about what she thought were the important elements of a first visit the DN talked about the referral and the information she got from that. The referral "... will tell you a little bit about what you are going into or what you think you are going into." (Pg. 3 para2). She then goes on to say that the reality may be different and gives an example of where your priorities would need to change

*Referral – access to patient – prioritises – action

(*Does this relate to the concept of correct information?)

DN1 mentions the information in the patients case notes but says that even if she has information from the case notes she likes to "... know what their insight is to what's going on and also the carer.." (Pg. 3 para. 4) so in this way she is almost testing out the patient/carers for their views.

Prior information/knowledge of household

The DN had visited this patient about a year ago for bathing assessment – service not commenced so had some prior knowledge of the patient. First thoughts prior to visit were 'something's changed'. However this was not her initial impression when she visited as she thought the same situation existed.

Getting information by observation

- watching the patient mobilise
- watching the patient and carer interact
- seeing if they can manage (Is 'manage' a red flag?)
- getting the picture that husband is stressed (Pg. 6) – (did some of this come from him trying to do the washing as we visited that morning because the husband stayed well out the road at the visit and said very little other than that were managing OK)

Getting information by questioning

- Asking patient if she knew why she was there (field notes FN)
- Asking carer about home help (field notes)
- Asking patient "what is your biggest worry?" (field notes)
- Asking about drugs and past medical history (FN)
- Asking about the use of aids (FN)
- Asking how does patient wash (FN)

It is clear that this DN got information from a range of sources. It is perhaps not useful to delineate how she got the information because the text highlights the integrated way she appears to get and use information. It is difficult at this stage to identify how 'getting information' relates to knowledge, but somewhere it does!

What knowledge are they using and why do they hone in on certain areas through their questions and observations?

My own hunch is that the environment of the home and presence or not of another family member has an enormous influence on their perception of the household and how things are managed within it. I think that they make quite a lot of judgements (or are they decisions) based on their initial impressions as they walk through the door (or even before as they approach the house). If this is so, then how do they learn this, are their impressions true and accurate ones, are they reliable, how do they know if their perceptions are correct – do they try confirm these perceptions through their information gathering?

Possible question for second interviews

What do you think is the most significant thing that influences you when you visit a patient for the first time? Followed up by "Can you tell me why that is?"

(They might need to think of a specific example to answer this? – I can hear them say 'every situation is different')

When asked for general comments about assessment the DN highlights the complexity of this process and says "...there is a lot of information gleaned from a first visit, often of course it's not completely correct information and it does take these two or three visits to actually, you know, think about what they've said, what's the families interpretation of or the patient interpretation of what's going on is different from yours, and it's about helping them with that as well" (Pg. 11 para. 6)

What is the DN meaning when she talks about not ‘completely correct information’

- Is it that she has not got enough information to fully grasp the situation?
- Does she think the patients/carers not giving her accurate information or are they withholding information?

Earlier in the interview the DN talked about “...not completely sure that that’s the full story and I would feel I would need to go back into that house a few times to get the complete picture...” (Pg.6 para. 1)

Is she equating correct information with enough information, or is she relating it to confirming her search for *the main thing*?

The DN talks about ‘finding a balance’ between the needs of the patient and the resources she has available. She talks about the patient being able to wash at the sink and how in fact that might make her borderline for taking on for bathing where resources are limited. On the other hand the patient is incontinent and has poor mobility. Getting information may therefore be influenced by resource issues, maybe the DNs are reluctant to get too much information in case the resources are not there to meet identified needs?

The DN talks about holistic care;

“I think it’s about being able to use all the knowledge and bring it all together, looking at the patient and not just at one thing like a leg dressing but going in and seeing the whole patient.” (Pg.13 para1).

How does all the knowledge and the whole patient relate to *the main thing*?

Would they be able to answer this question;

What is the most important thing that helps you decide whether or not you have collected enough information at the first visit?

If the *main thing* is a real issue would this question help to untangle that?

Thoughts

This section of getting information, investigating and interpreting may be fundamental to the whole study. It is likely that the DNs are highlighting their underpinning knowledge and values by the way they approach this area. The challenge is to relate the information they seek and subsequently use to their knowledge base and how this informs their decisions and subsequent actions.

So what is the relationship between **knowledge, decisions and actions** and which comes first?

Code note: Knowing that and knowing how

Throughout the text and from my observations there are examples that quite clearly relate to *knowing how* and *knowing that*, for example;

Knowing how to communicate (non-verbally)

Knowing how to talk to patients
 Knowing how to extract information
 Knowing how to listen and pay attention
 Knowing how to talk about finances
 Knowing how to promote independence

Knowing that;

Knowing about benefits
 Knowing about other services
 Knowing that caring for a wife with a disability may cause stress
 Knowing that a carer would benefit from a break
 Knowing that certain equipment might make life easier
 Knowing that you must promote independence because the nurse is only there for a short period of time
 Knowing that incontinence may cause skin breakdown

The DN identifies that the DN course had given her the 'knowing that' but she appeared to be lacking the 'knowing how'

She said "Em although I had this knowledge I wasn't really sure how I was going to put that all into practice so definitely it was you know, how am I going to do this so I felt very em... frightened about going out there making the right decisions. So although it gave me the knowledge (the course) it didn't give me the confidence" (Pg. 2 para 6).

The DN appears to be linking confidence as part of the *knowing how* of first assessment visits. I think confidence as a vital part of visiting patients for the first time is reflected in most of the other interviews. DN1 goes on to describe getting this confidence by 'bringing in the knowledge' and by reflecting in and on action.

*How does knowing that and knowing how relate to decision making? I need to *know that* poor mobility and incontinence may result in poor hygiene and skin breakdown. I need to *know that* if the patient is receiving the attendance allowance that it may be appropriate for them to use this to pay for a bathing service. So I need to *know how* to raise this issue with them and decide on a course of action.

From this interview elements of knowledge that relate to my reading of the literature are identifiable from this data particularly in relation to scientific and experiential aspects of knowledge. However personal knowledge and the impact on decision making and the impact of the context is harder to identify. The knowledge of how to assess is derived from theoretical principles but I cannot learn to do it and apply it to individual situations by simply reading about it.

Rolfe (1998) writes some very interesting material about personal theory, fuzzy logic and fuzzy decision making – fascinating stuff which although complex seems to me to give some explanation to this lot! Personal theory is context specific, referring only to this patient, in this situation and exists only in relation to practice, arising out of a specific practice situation (Rolfe 1998). Rolfe argues that the nurses' own professional judgement, consisting of a combination of experiential, personal and scientific knowledge is a way of knowing in practice that places technical problem solving within the broader context of reflective enquiry. (So is professional judgement the vehicle for using and processing knowledge which ultimately results in the action? Rather like the nursing process which is only the vehicle for the use of nursing models and not a model in itself? The nursing process is classed as a decision making model).

Interview DN1 Story line

I have spent three days listening to and looking at the data for DN1 coupled with reading around methods of analysis and re-visiting some of the nursing knowledge/decision making material.

As anticipated it is extremely complex and the data produces far more potential questions than answers. However it would appear that there is a 'story line' in the data that goes as follows.

DNs need a different knowledge base to work in the community - a broader knowledge base incorporating the social sciences. This DN equates having the appropriate knowledge to work in the community with education and experience and suggests that often those of lower grades do not have this ability to look further and think laterally. In relation to assessment she identifies the need to interpret assessment frameworks in a broad way and to think very carefully (? investigating) about the information the patient and family are giving, can she take that at face value or is there something else?

The notion of a main thing (or reason for visiting on an on-going basis) is not a concept that I have come across before – although all 11 visits have focussed on the main reason for referral despite the DNs talking, to a woman, about this broad based, holistic approach they adopt. However they have demonstrated examples of where the assessment task has to be redefined. This would confirm my reading of the literature in relation to nurses adopting the hypothetical deductive approach where they set out to confirm or refute the main reason for visiting. From her actions DN 1 focussed on the reason for referral throughout.

Scrutiny of the data reveals how the DN got the information she was looking for but what is not clear is why she approaches it in the way she does. This search for, and interpretation of, 'information' is at the crux of the assessment process and the knowledge underpinning practice – how can it be uncovered? My own hunch is that the DN has formulated judgements within seconds of meeting the patient and/or family for the first time. This seems totally irrational and I can hardly justify it to myself. The latest writing of Gary Rolfe and his concept of personal theory seems to relate to my gut feelings – personal theory is constructed in practice and relates to *this* patient, in *this* situation by reflecting in action. It is constructed in practice as a direct response to a problem and can be immediately applied. But there are problems – how can practice be tested/evaluated?

Professional judgement as a vehicle for turning scientific, experiential and personal knowledge into action is a useful way to think about trying to uncover what is happening. By reflecting on the action of assessing patients with hygiene needs the nurse translates this practice based experience into personal knowledge. This personal knowledge is stored away for future use and is taken back to the clinical situation to deal with the problem of patient x. Personal and experiential knowledge can be used to generate personal theory through the process of reflection in action. When confronted with the problem of whether to offer this patient a bath or not, the nurse employs professional judgement, and draws heavily on personal knowledge she has built up to reach a decision on how to respond. She knows that a stressed carer may lead to other problems, she knows that a chaotic house may signal a household that is not coping with daily living. She also knows that incontinence may lead to skin breakdown so washing down at the sink, which the patient says she can do, may not suffice. She also knows that some physical aids may alleviate the need for a nurse to visit so she decides to come back next week and observe the patient in action. She also gets feedback from the patient and carer immediately to her decision.

I would be interested for comments on this possible sequence of events – does it fit in any way - because the more I think about it, the more complicated it becomes.

Rolfes' model of professional judgement makes more sense to me than most of the others I have looked at and the focus on context is particularly relevant.

Appendix 13

Code notes and story line for DN3 – 15 April 1998

This was an excellent visit and interview. This DN was totally relaxed with me being there and she talked freely throughout. My feelings are that she gave clear rationales for her actions and decisions – more so than the two data sets analysed so far. She talks a lot about the interpersonal aspects of care and the importance of presenting herself as a professional.

Code note: Broader Outlook (holism, whole picture)

DN3 does not use these words (broader outlook) but describes in some detail what she is looking for

“.....Going in I was just having a wee look to see if we were going up steps, I was thinking about access for the gentleman with his stroke. If he could get out and we did go up two steps. And I noticed that it's quite a bit from a carpark.....Smell, you just can't help but think oh is there a smell in here.....the house was fine.....everything looked nice and clean.....it was warm.....but he had his fire.....he seemed quite content there, his son was with him.....he was watching the telly. Thought his chair looked a bit iffy, you know he was sitting on all those foamy cushions.....The bathroom is well set up, I didn't look at the kitchen but his son assures us that he is close by.....the man looked well nourished” (Pg. 9)

When asked what she would have wanted a student to get out of the visit she responded;

“...hopefully a sense of holism.....that I'm not really just interested in you know his skin for his hygiene needs but just like trying to, a wee flavour of getting the whole picture as much as you can, as much as anybody will let you see. And trying to just sort of be a professional and you know treat people with respect and they'll respond in a positive way”. (Pg. 23)

Code note: Building a relationship

DN3 talked throughout the interview about building a relationship. This relates to 'getting to know the person' which may be a major theme from this first round of data analysis.

DN3 had worked as a relief DN and talked about how different it was when you had your own caseload;

“...you can sort of really form a relationship with a patient built on a mutually sort of achievable and observable goals that every body wants.....if I take on a new person we can start from day one and build a relationship together” (Pg. 2).

DN3 talks about giving the right impression as being important in establishing the relationship (Pg. 3) and appearing professional. She said “...like today I phoned up before I went so the man know I was coming, so that was good, he knew what time to expect me so he didn't think who is this appearing on my door, so I think that is a good first impression to make,to sort of build a bit of trust and confidence in our service.....” (Pg. 4).

DN3 talks about it being very much a two-way relationship:

"I think it is very important to be able to give people information about what realistically our service can offer them and also I think it is important for them to get a chance to realistically tell us what they would expect from our service.....and hopefully we can all find a common ground" (Pg. 4)

She goes on

"...I think it's setting the scene...I think you can do an awful lot of damage or an awful lot of good on a first visit...trying to maintain this approachable appearance but also very aware that I am wearing the uniform of my profession and I really should be seen to behave and act in a certain way" (Pg. 5)

When asked how she thought she did that she gave a splendid example which matched exactly my impressions of how she approached the visit:

"Well, I'm very conscious of calling him by his proper name. I would never ever go in and say, "well how's it going John?" I think that can be quite demeaning and condescending to speak to someone who could be my grandfather in that way so I make a big effort never to do that and I always like to introduce myself to him although in this case his son was there I made a big conscious effort to make, he was my focus, he was my patient you know rather than speaking through his son. And I shook his hand 'cause I think that's polite, and I brought my chair in so that I tried to make sure he could hear what I was saying and he knew I was there for him but I didn't want to make him feel threatened so I kept a wee distance from him so em really I was conscious of my body language. Hopefully tried to use language he would understand, I tried to well, I tried to ascertain what his background was that kind of thing, now he told me he was from the farm so that obviously makes you think in a certain way. I myself was brought up on a farm so that maybe helps a wee bit". (Pg. 6)

During the visit the DN decided that she would bath the patient there and then. When asked why she decided to do that she said that it gave her the opportunity "to explore his continence issues in relative privacy because he might not have wanted to discuss that in front of his family no matter how close" (Pg. 10). She continues.. "I mean everybody pays lip service to you know and how are your bowels and all this kind of stuff but how many people would realistically want to answer that in a room full of four people....Whereas I felt it was just him and I nurse and patient in a real nurse patient situation...." (Pg. 11)

Code note: anticipatory care

This is an interesting concept that I think is reflected in some of the other interviews. This notion of getting to know the patient and making/keeping contact in case their condition deteriorates is not something I have thought of before (although I have done it!). Nolan and Grant identify anticipatory care in their typology of family care.

When asked what she thought was the most significant thing in her offering a continued service for bathing DN3 said;

"Keeping a foot in the door I think, just making sure that if he deteriorates that we can help him, that we can get in there quick to help him. It might well be that he will improve cause

it's very soon after his stroke and he has done very well in two months to be walking around almost independently" (Pg. 12)

When asked about her plans for the future care of this patient the DN said

"Well now that he's going to be admitted onto my caseload now for ongoing supervision and it will be the auxiliary nurse who will sort of feedback from every visit if there is any deterioration in his skin and I'll pop in maybe every couple of months just to see how things are going...it's just really a case of making sure he knows where I am, his family know where I am and if anything does come up they know how to get me" (Pg 10)

As this patient had a stroke he is at risk of future strokes and the DN obviously recognises this. This highlights how important getting to know the patient and establishing a relationship is to her as she obviously thinks it will be easier to help if she knows them and vice versa.

Code note: the main thing

Like DN2 this DN does not use these words but again the visit revolved around the reason for referral – a bath. DN3 gives a superb example of where she is combining the functional, social and contextual aspects of assessment before and during the visit.

"Going in I was just having a wee look to see if we were going up steps. I was thinking about the access for the gentleman with his stroke. If he could get out and we did go up two steps. And I also noticed that it's quite a bit from the car park so if the man needed transport he would have to walk quite a wee bit so I noticed that now that I think of it. Em... smell, you just can't help but think oh is there a smell in here and you know old man living alone, but there was no smell in here, the house was fine and em I was looking and everything was nice and clean. Em...it was warm and it's a warm day anyway but he had his fire, he has access to his fire and eh he had his telly on so, and he had, well it's difficult to say how happy he was, cause who knows who's truly happy, but he seemed quite content there, his son was with him, he was relaxing, or looked to be relaxing, he was watching the telly. Thought his chair looked a bit iffy, you know he was sitting on all those foamy cushions I feel that looks a bit dodgy but perhaps that's been explored, but when I, I will feed back to the social worker and ask him if he's been in touch with the OT about getting him a you know safer chair. So really just looking at the environment, saw the bathroom. The bathroom is well set up em, I didn't look at the kitchen but his son assures us that he is close by and he's got a grandson that looks in every night so the man looked well nourished and all that so I didn't think the kitchen was a big issue. (Pg. 9)

She goes on to say

"....there was no great revelation when I went in the living room door. It was just that it was a comfortable house, he was clean, he was well dressed, well nourished. He was well attended, he seemed OK.

This illustrates that she did not think there was anything significant – the set up seemed to be fine. This text is a superb example of the integrated nature of assessment. The DN moves between functional elements, social elements and contextual elements. She uses some of her previous knowledge – the stroke and the involvement of the social worker to

inform her assessment. She demonstrates clearly the use of all senses in the assessment process.

The DN does not identify anything significant from her assessment so at this stage it is not clear why she is taking the man on for bathing. She does go on to explain why and this will be considered in relation to this decision later.

In relation to the main thing the visit did revolve around the reason for referral – the bath. The DN did not seem to think there was anything significant from her assessment and what she did was bath the gentleman at the visit saying that she thought it was difficult to assess for a bath without having a go.

“.....I really cannot see how you can do a bathing assessment without having a go, seeing how the person performs in the bath” (Pg. 14)

Code note: Interpreting information and correct information

Written information

Son referred patient, as he needed help to bath. DN had found out patients' medication from notes in surgery prior to visit. Knew that he had been in hospital following a stroke.

Prior information/knowledge of household

The DN knew that the patient was recently discharged home from hospital. The son told her on the phone that his dad's memory was poor and asked her to visit when he could be there. So she also knew that the man lived alone and that he was 89 years old. She knew that social work was involved and that the patient had a daily home help.

Getting information by observation

Observing the environment outside the home (car park, steps)

Observing the home for smell, warmth

Watching the patient mobilise

Looking at the chair the patient is sitting on

Looking at the bathroom

Watching father and son interact with each other

Looking at how the patient was dressed

Looking to see if patient was well nourished

Looking at his skin

Observing that the patient was wearing pads and net pants

Observing that he has access to his fire and television

Observing that the patient “was well attended” and “he seemed OK”

Getting information by questioning

Asking how patient felt about getting help with bath (field notes (FN))
 Asking patient about stay in hospital (FN)
 Asking patient about his help in the morning (FN)
 Asking patient about hearing aid (FN)
 Asking about vision/glasses (FN)
 Asking about appetite (FN)
 Asking about social activities (FN)
 Asking about his working life (FN)
 Asking about when he was to return to hospital for check up (FN)
 Asking about family support (FN)
 Asking about attendance allowance (FN)

As with DN 1&2 this DN got her information from a range of sources. She perhaps spelled out more clearly the visual/sensory cues that she used. Again it would seem that the state of the home influences how the DNs approach the assessment. This DN seemed reassured by the warm clean home, the appearance of the patient and the presence of his son.

Prior to the visit the DN had commented that as the son had referred his dad it might be a case of the wants of the family being at odds with the needs and wants of the patient. This was not her impression when she visited as she felt neither son nor patient was putting any pressure on her to provide the service.

DN3 Code note: knowing how and knowing that

Knowing how

Knowing how to introduce herself (nurse)
 Knowing how to build a relationship
 Knowing how to communicate non-verbally
 Knowing how to give the right (professional) impression
 Knowing how to make a good first impression
 Knowing how to give information about the service
 Knowing how to negotiate (to find a common ground Pg. 4)
 Knowing how to do good and avoid doing damage at the first visit
 Knowing how to make the patient the focus
 Knowing how to be polite
 Knowing how to instigate appropriate conversation
 Knowing how to address issues of continence
 Knowing how to help the elderly patient get in and out of the bath safely
 Knowing how to use bath aids
 Knowing how to discuss finance
 Knowing how to contact other professionals

Knowing that

Knowing that the patient has had a stroke
 Knowing that the patient has family support
 Knowing that the patients short term memory is poor
 Knowing that the patients mobility, sight and hearing is poor
 Knowing that the patient wears pads and pants
 Knowing that it is important to be polite
 Knowing that it is important to choose carefully where to sit when talking to someone
 Knowing that it is important to give the patient undivided attention rather than talk through his son
 Knowing that the patient was a farm worker
 Knowing that the patient has daily home help
 Knowing that the house is warm and clean
 Knowing that the patient is well nourished
 Knowing that it is important to maintain dignity by not asking personal questions in front of others
 Knowing that it is important to check the condition of the patients' skin
 Knowing that with the patients medical history he may deteriorate
 Knowing that the patient may benefit from going to day care/lunch club
 Knowing that the patient may not want to go to day care/lunch club
 Knowing that the patient receives attendance allowance
 Knowing that private agencies may meet some needs
 Knowing that home care do a good job in meeting the needs of some patients
 Knowing that resources are limited and the population is ageing
 Knowing that to assess a patient you need to pick up a bit from every aspect of their life
 (Pg. 22)

This DN clearly demonstrates a wide knowledge base encompassing knowing that and knowing how. She displays a sophisticated understanding of interpersonal communication and a lot of her knowing focuses on this area. It would appear that her knowing fits into the four areas already identified in the typology – getting to know the patient and family, knowing the community and the context.

Story line for DN3

This was an excellent visit and interview and whilst there are recurring themes with DN1 & 2 there are two particular areas which I felt this DN emphasised. Firstly, the whole area of building a relationship was explicit at this visit and throughout the interview. DN3 concentrated on the business of establishing a relationship and building the assessment on that.

She clearly explained her rationale for her actions – the determinants are there to pick out. The concept of making and sustaining contact in case the patient needs more care in the future is very interesting. I think some of the other DNs talk about this in later interviews. I have called this anticipatory care, a term used by Nolan & Grant in relation to a typology of family care. DN3 used her knowledge of strokes to decide that this patient, an elderly gentleman, may need more care in the future and perhaps at short notice. She is anticipating future care needs.

Like DN1 & 2 she seems to be using and demonstrating a range of knowing that and knowing how that falls into the four areas identified in the typology – getting to know the patient, getting to know the family, knowing the community and knowing the context. At this stage the amount of knowing from the first three interviews is rather overwhelming in terms of setting it out in a typology – this is going to need a lot of work to get it into something that does not lose the essence of DN practice but at the same time is manageable for those looking at it.

I think DN3 has given some excellent text in relation to the assessment process. Her account does not fit neatly into a nursing process type approach (as you would expect – the reality of practice couldn't be fitted neatly into a linear model). I think I should look at the family systems theory and the structural, functional and developmental aspects of assessment outlined in this work.

I think there are potentially two exemplars in this interview. The first is where the DN describes how she went about setting the scene and starting the relationship with the patient (Pg. 6) and secondly, the things she was thinking about when going into the house and during the visit (Pg. 9).

Appendix 14

Setting the agenda, Visiting Mary

DN 8 visited an 85 year-old lady with a history of venous ulcers. The purpose of the visit was to determine whether her leg ulcers were of venous or arterial origin by carrying out a Doppler Test. The patient (Mary), a pleasant immaculate and agile lady, answered the door and invited the DN and the researcher into her home.

After the DN introduced herself Mary told the DN that she had seen the GP that morning and had a blood test taken. Mary thought that her leg looked better today. The patient was removing her stockings as she talked and the DN quickly began to remove the bandages while asking if the leg was comfortable at night. The DN went on to explain the test she was going to carry out and asked the patient how she was feeling. Mary said she was feeling well and pleased that when the GP had taken her blood pressure that morning that it was 'good'. The DN explained that she would take her blood pressure in her arm and her leg to see what type of ulcer it was so that it could be treated properly.

Commentary

At the start of the visit the patient offered some information about her visit to the doctor and her own opinion that the leg was looking better. The patient seemed to assume that imparting the information from the doctor was important to the DN. At this point the patient influenced the agenda by starting to remove her stockings. The DN responded and quickly began to undertake her tasks and removed the bandages whilst seeking and giving information. Again Mary gave the DN information about her visit to the doctor. At this stage of the visit the patient was giving information and the DN was carrying out aspects of her task whilst seeking and giving information.

As she talked to Mary, the DN was using an assessment framework for leg ulcers as a visual guide and recording only minimal detail throughout the visit. The DN asked Mary if this was her first ulcer. Mary told us she has suffered from ulcers from age 17 when she worked in a cold, damp factory. She talked at length about her working days and how hard it was. The DN asked Mary how long this ulcer has been there for - Mary answered three weeks. The DN asked Mary if she had varicose veins or any previous surgery. Mary said she had no varicose veins but had three operations in the 1950's for a sore heel and polio as a child, all in the same leg.

Commentary

During this part of the visit the patient gave the DN a lot of information however this was in response to her questions. The DN recorded some baseline information as she examined the patient's leg and continued to ask for more information.

The DN asked about previous health any problems relating to high blood pressure, heart problems, strokes or diabetes. The patient answered that she suffered from high blood

pressure but had no problems in relation to the others. The DN said she would test the patient's urine. The DN asked patient if she had any allergies - no - and the DN went off into the kitchen to check the patients medication.

Commentary

The search for information by the DN continued and the DN went into the patient's kitchen to check medication. When interviewed, DN 8 commented on how well kept the patient's house was and referred to her observations of the kitchen. DN 8 concluded that everything was fine and there was no evidence that the patient was not coping.

On her return from the kitchen the DN explained about the Doppler procedure and how it might be a little uncomfortable. The DN took the leg measurements of the patient, and asked how about how well she could move her ankle. The DN then carried out the Doppler assessment.

During the procedure the DN asked the patient if she was all right and told her again why she needed this information. After the test the DN told Mary that the test had shown that the leg had a poor blood supply and should not be tightly bandaged. DN said she would speak to Mary's GP.

Commentary

This procedural part of the visit was entirely led by the nurse who in addition to carrying out the test, sought and gave additional information.

Mary told the DN she did not want to go back to the hospital. The DN asked if there was a family history of ulcers. Mary said that her sister had ulcers. The DN said she would dress the wound and would visit her at home (rather than the patient coming to the surgery as had been the norm). The DN asked Mary if she had any pain and Mary said she had none.

Commentary

In response to the DN's comments that she would speak to the doctor the patient told the DN she did not wish to go back to hospital. At this point the DN started to broaden out her questioning by asking about family history and seemed to reassure the patient in relation to her comments about hospital by saying that she would visit at home.

The DN dressed the ulcer whilst asking patient if she was waking at night. Mary said it had been sore at the weekend but was now fine. DN asked Mary if she had help at home. Mary said she had a home help twice a week. The DN asked Mary if she was able to do her housework and Mary said she could manage most of it. The DN asked Mary if she managed to get out. Mary said that she did not go out so much now but went to the hairdressers on a Thursday. DN asked patient if she managed her own cooking. Mary said yes she cooked a lot and liked to bake and make soup.

Commentary

The DN asked a range of questions that related to the wider aspects of Mary's life and how she was managing generally.

Mary said that she recently had two operations. The DN asked Mary if her eyes were better. Mary answered yes and DN asked her if she was still having eye drops. Mary answered no. The DN applied dressings to the ulcer and said she would visit again later in the week to redress the wound and next week to redo the test. The DN went to the bathroom to wash her hands and leave the patient a urine specimen bottle. The DN asked Mary to provide a specimen of urine for the next visit. Some general conversation followed then the DN and researcher left.

Commentary

In the final stages of the visit, the DN completed her tasks and gave Mary information about future visits. At the start of the visit there was some evidence that the patient was taking the lead. Fairly quickly into the visit the agenda of the DN seemed to dominate and whilst the patient gave a lot of information it was in response to questions asked by the DN. The one exception was in relation to her eye operation. Throughout the visit the DN integrated information seeking and giving with carrying out her task. She asked a range of questions that related to the wider aspects of the patient's life and the general impressions of the DN following the visit was that the patient was coping very well with many aspects of her life apart from needing some attention for her leg ulcers.